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IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NORTH CAROLINA

WESTERN DIVISION

UNITED STATES OF AMERICA, :

Petitioner, :

v. : CASE NO. 5:10-HC-2009-FL

DANIEL KING, :

Respondent. :

BENCH TRIAL (VOL III)

OCTOBER 19, 2011

HONORABLE JAMES E. GATES, PRESIDING

Reported by: Glynde M. Jones
Court Reporter
Notary Public

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THE COURT: Good morning, folks.
AUDIENCE: Good morning, Your Honor.
THE COURT: Any housekeeping matters, folks, before we get started?
MR. BELL: Not from the Respondent, Your Honor.
MR. GRAY: Not from the Government, Your Honor.
THE COURT: Very good. In that event, Mr. Bell, I'd be happy to hear any evidence the Respondent cares to --
MR. BELL: Your Honor, at this time, we would call Doctor Fabian Saleh.
COURT CLERK: Can you come up and be sworn, please?
FABIAN SALEH, MD, having been duly sworn, was examined and testified as follows:
COURT CLERK: Please state and spell your name for the record once you're seated.
THE WITNESS: Sure. My name is Fabian Saleh. F-A-B-I-A-N is my first name. S-A-L-E-H is my last name.
THE COURT: Doctor Saleh, let me just remind you -- I'm sure you're used to testifying. If objections are made to a question that is posed to you, I would

request that you not respond to that question until the objection is resolved, and also -- and I'll remind you in anticipation in any event, but if your testimony which I anticipate will extend over breaks when you do come back and resume the witness stand, you do, of course, remain under oath.

THE WITNESS: Yeah, sure.

MR. BELL: Thank you, Your Honor.

EXAMINATION

BY MR. BELL:

Q Doctor Saleh, just for housekeeping purposes, there are several notebooks in front of you. The black notebooks are the Respondent's exhibit and the white notebook are the exhibits of the Government. You may be asked to refer to those. Doctor Saleh, I'm going to ask you to refer to Exhibit Two in the -- in one of the black notebooks, the top black notebook, so you might want to go --

A Yes.

Q Doctor Saleh, I've asked you to refer to a document that's been marked as Respondent's Exhibit Two. Can you tell The Court what that document is?

A This is my resume or curriculum vitae.

Q And the date of that document is what?

A It's January 26, 2011.

Q And the document contains what?
A Well, it's essentially a background of my career, describes where I went to school. It describes where I was born. It describes my current position and my various academic affiliations, various presentations I have given Nationally, internationally, and books, articles I have written.
Q I'm going to be asking you some questions in reference to those areas. If you need to refer to Exhibit Two, please feel free to do so. Have there been any -- that's dated January 26, 2011. Have there been any additions that would be made to that document since that time?
A Yes. I apologize. I didn't realize it. I haven't given you the most recent updated CV. There have been additional publications, additional presentations, and I think that's it. I mean, just presentations and publications.
Q Thank you. Can you tell The Court what you do for a living, Doctor Saleh?
A I'm a forensic psychiatrist and a child adolescent psychiatrist.
Q And if you would, tell The Court where you're employed.
A I'm presently employed at Mass General Hospital

in Boston, and my position is with the Lowell Psychiatry Service at that hospital. And I'm also a part of a staff at the -- what we call the West End Clinic at Mass General where I see and treat patients who are afflicted with substance abuse disorders and also various forms of mental illnesses. I also run a small child psychopharm clinic at Mass General and I'm assistant professor of psychiatry at Harvard Medical School.

In addition to that, I'm the director and founder of the Sexual Behaviors Clinic that's affiliated -- and it's in Central Massachusetts in Worcester, and we also have a satellite office which I run in Lexington, which is closer to Boston, so we serve Massachusetts essentially, and, again, it's also called Sexual Behaviors Clinic, part of Community House Clinic. That's what I'm doing.

Q How many languages do you speak, Doctor Saleh?

A Four.

Q Do you speak them fluently?

A Well, it depends. If I'm not too tired, I probably speak them rather fluently, yes.

Q Which languages do you speak?

A German is my primary language. English is -- speak Italian and Farsi.

Q Where were you born, Doctor Saleh?

A In Germany --
Q You're a psychiatrist, correct?
A That's correct, yes.
Q We've heard testimony earlier in this trial from psychologists. If you would, explain to The Court what the difference is between a psychiatrist and a psychologist.
A Yeah, sure. With regard to psychiatrists, I mean -- psychiatrist is somebody who would have to go through medical school and earn a medical degree, and after -- and, again, as I said, I did my training overseas in -- I did my high school in Germany, but then my medical school I did in Florence, Italy, and there it's six years at a minimum that you have to go through medical school, and as part of our training there, we have to also write a medical thesis. And so at least with regard to my training in medicine, it was six and a half years, plus the medical thesis that I wrote. And after you complete this, you have to -- you become a physician, then take the state license. I took it in Italy and then Germany, and I'm licensed also to practice medicine in Europe.
And psychologists, as far as I understand, they go through, I think, four years or six years of training and then earn their Ph.D or PSY.D. I think the

difference between the PSY.D and Ph.D is that Ph.D -- that they do research and the PSY.D -- and, again, I'm not 100 percent certain about this. As far as I know, they are not required to do research and it's more clinical and more focused on clinical medicine. Now, with regard -- and that's, I think, the difference in terms of training.

Now, to become a psychiatrist, I have still to go through residency, and in my case, I had to take the Boards -- the American Boards for which I trained in Oxford and then passed the Boards, came to the United States, did an internship first, and that did include six months of psychiatry, four months of medicine, and two months of neurology, and thereafter I -- and, again, I've talked a little bit about myself. This would best describe maybe the difference between the psychiatrist and the psychologist. And then you go into general psychiatry or adult psychiatry, and in the United States, it's another three years of training to become a general psychiatrist. Now, in my case, I did two years of a fellowship in child and adolescent psychiatry prior to doing my general training.

Q Doctor Saleh, just let me stop you there. Explain to The Court what a fellowship or a postdoctorate fellowship is.

A Sure. So essentially what you do is once you do the general psychiatry training, the residency, then if you choose, you can take further subspecialties, and there are various subspecialties you can take in psychiatry. One of them would be, for example, the child and adolescent psychiatry fellowship which is two years of additional training on top of the four years you do, and then there are other fellowships like forensic psychiatry. Depending on the program, it may be one to two years, and then -- geriatric psychiatry, substance abuse psychiatry, or it's actually addiction psychiatry.

Q In your particular case, just so I can review and make sure we have it correct, you indicated that you went to undergraduate school and medical school in Europe?

A In Europe, yes.

Q Then you came to the United States and did an internal medicine residency here in addition to neurology and psychiatry?

A Before coming to the States, I went to Germany and did research in Heidelberg in schizophrenia and then with this time period in Oxford, I then came over to the States and did my residency in the United States.

Q And you did the internal medicine in neurology and psychiatry resident -- or internship?

A Internship, yes.
Q Then you did your residency, you said, in child and adolescent psychiatry?
A That's correct, yes.
Q And then you did a residency -- where did you do your residency, that particular residency?
A The adult residency -- I was recruited to Johns Hopkins Hospital. I did it at Johns Hopkins Hospital University. I did my residency there.
Q And you mentioned various fellowships that you can do, subspecialties, I guess, in psychiatry. You mentioned forensic psychiatry. Did you do a fellowship in forensic psychiatry?
A I did a total of three fellowships. I did -- one was child and adolescent psychiatry, and then I did a fellowship in motivated behaviors, and that was a fellowship that I did while I was at Johns Hopkins, and that had to do with substance abuse, sexual disorders and paraphilic disorders. And as part of that fellowship, I went to the Royal Ottawa Hospital in Canada and worked with the doctors there. After I finished that fellowship, I'm still part of Johns Hopkins, I then got recruited to join the forensic fellowship program in Massachusetts under Paul Applebaum and did my forensic fellowship.

Q Where was that?
A In Worcester, Massachusetts at U Mass Medical School.
Q Now, were the programs that you participated in, both overseas in Europe and since you've been in the United States, the training you had here, were those programs accredited?
A Yes, absolutely.
Q Explain to The Court what accreditation means with regard to a particular program.
A As far as I know, I mean -- I don't know exactly what goes into it. I mean, there are many programs that train people and provide training in various forms, and for a program to be -- to go through the accreditation and be recognized, they have to meet certain requirements, and as far as I can say at least, for example, with our forensic fellowship program at Mass General with Harvard Medical School, there are requirements they have to fulfill in terms of the training they offer, in terms of the lecturists they have, the teachers they have in terms of how many hours of supervision the fellow would be given, and it's -- as far as, again, I know it's a governing Board Nationally that then gives them the certification that they can train, and whoever then comes out of that program is a

recognized, for example, forensic fellow or -- out of that program that has passed that certification process.
Q Now, during your residency -- what is a chief resident?
A Well, a chief resident is somebody who is -- it depends on the program, I have to say, but typically it's somebody who is -- is involved in the supervision, training of other residents, the junior residents and their own fellow residents, and, again, depending on the program, some programs have more than one chief resident. Other programs have one chief resident, but it's somebody who because of the work was given the privilege to be part, if you want to, of the administration. They help with the supervision of residents and overseeing of the training of the residents.
Q And during your residency, were you appointed as a chief resident?
A I was, yes.
Q Now, after your training, after you completed your training, did you participate in any sort of Board certification process or anything like that?
A Yeah, sure.
Q Explain that to The Court, if you would, please.
A Well, what I had to -- or, actually, not had

to. I mean, people can work as psychiatrists without going through the Board certifications, so what I did though is I took the Board in psychiatry and neurology and became Board certified and -- specialty -- I took my Boards in forensic psychiatry.

Q So you're Board certified in three different areas?

A Actually, the fellowship in child and adolescent psychiatry I did not go through the Board certification process because I did it my -- my general residency and I was happy with just being a fellowship trained child and adolescent psychiatrist, but for the general psychiatry and forensic psychiatry, I'm Board certified.

Q If you would, explain to The Court what your work experience has been since, you know, you completed your training and to the present time.

A Let's see. The first thing I did, as soon as I got done with my training, forensic fellowship in Massachusetts, I started the sexual -- we called it actually initially Sexual Disorders Clinic, changed the term or name of the clinic to Sexual Behaviors Clinic, so that was founded September of 2003 -- would be a few months after I had completed my training, and the purpose was really to serve Massachusetts and provide at least Central Massachusetts at that time with a

clinic where we would see patients presenting with various forms of sexual disorders. So that's one thing. I became the founding father and director of this clinic which has been in existence ever since.

And in addition to that work, I also ran various programs through U Mass. I was director of a couple programs at U Mass and -- for example, child diagnostic program and other programs. I would have to look at my CV to get a better sense of what other things I did, but there was several other things I did in terms of child psychiatry while at U Mass.

I was part of the Lowell psychiatry program, and as part of that, I was actively involved in the training and supervision of forensic fellows through our program at that time and also students and residents coming from abroad. I had people coming from Italy to join me and get experience in sexual disorders. And so I did this for several years and then was recruited to join the Lowell psychiatry program where I have been ever since and where I do forensic work and -- both private and State related court cases, I do -- I continue to run, as I said, the Sexual Disorders Clinic or Sexual Behavior Clinic where I see and treat patients presenting with various forms of sexual disorders, including paraphilic disorders, various forms of mental problems and -- so

the primary problem they present with is some sort of a sexual problem. It can be a paraphilic disorder. It can be problematic sexual behaviors. Some of the patients present with developmental disabilities, others with mental health problems and others just with sexual disorders, so that I -- treat patients there, and then -- so that I continue to do.

As mentioned, I am part of the Lowell psychiatry service where I do forensic work and then also now run a Friday afternoon clinic for children where I treat children and adolescents, and then I also see patients presenting with substance abuse problems at the West End Clinic, and this clinic, I'm there twice a week on Tuesdays and Fridays and treat patients with various forms of substance abuse.

Q Do you have any faculty appointments at this time?

A Yes.

Q Could you tell The Court about those?

A As I actually mentioned previously, I -- faculty -- I'm assistant professor of psychiatry at Harvard Medical School at this point.

Q What about any publications and presentations you may have done in the past? Tell The Court about those, if you would, please.

A I mean, I have done a number of presentations, I mean, both locally in the Boston area and I've done many presentations to residents and students at Harvard Medical School, law students at the Harvard Law School, for example, and have also presented Nationally and internationally to fellow colleagues at various organizations and was invited to present also to physicians, nurses, various providers throughout the Department of Developmental Services, attorneys, defense attorneys, prosecutors, judges. I've presented over the course of the years and probably have presented more than -- as far as I can say now -- 100 times over the years and then have published in the field of sexual disorders, paraphilic disorders, and recently we published a book through Oxford University Press on the topic of sex offenders and have had authored several chapters in this book as well and -- in the process of writing two books right now. One is on technology and sexual behaviors among juveniles and one is on child forensic psychiatry.

Q How about any boards or committees related to -- specifically to forensic psychiatry? Do you serve on any of those types of organizations?

A Yeah, sure. I mean, I'm the past president of the American Society of Adolescent Psychiatry and went

through the ranks of being a member at large and then was secretary for a couple of years and then vice-president and then became the president several years ago and now am past president.

In addition to that, I'm a member of a number of organizations across the US, and one of them would be, for example, the American Psychiatric Association. I'm an active member of the American Academy or Psychiatry -- there I served as a chair for several years on the sex offender committee, as of, I think, just a couple years ago and then was the chair of the child psychiatry and the law committee -- also through the American Academy of Psychiatry and the Law and have served on a number of other committees through that same organization over the years and am a member of the American Society of Forensic -- let me see -- Academy of Forensic Science. I'm a member of that program and chaired -- was a program chair of that organization at one time.

And I'm a member of the American Academy -- actually, it's the American -- I don't even know what that stands for. American Association for the Treatment of Sexual Abusers, I'm an active member of that organization and have been a member of other organizations nationally, but what I just remembered,

also, I'm chairing the sexual interest group through the Massachusetts Psychiatric Society, have been a chair of this interest group for I now believe almost -- if I'm not mistaken, eight or nine years and have been involved in MPS organizations, Massachusetts Psychiatric Society also for several years.

Q Now, you indicated that you do forensic evaluations as part of what you currently do.

A Yes, sir.

Q Do you also do non-forensic type evaluations?

A Yeah, sure.

Q Explain that to The Court, if you would.

A I mean, I do -- I have quite a busy forensic practice and see many cases over the course of months, for example, but then in addition to that, I have a pretty active clinical practice where I see, per the request of State organizations, regionally or out of State patients or individuals presenting with problematic sexual behaviors, including people with -- say with necrophilia, pedophilia, sexual sadism, people who have identified conditions or where the providers wonder if the person suffers from a condition or if a diagnosis is accurate. So somebody may be given a diagnosis, say, of pedophilia for some behavior they may have engaged in when they were, say, young adults, and

that patient may be then referred to my clinic for me to render an opinion as to the accuracy of that diagnosis.

And along those same lines, courts have approved funds many times for me to do what we call a Massachusetts independent medical examination which amounts to a second opinion where I essentially am asked to render opinions with regard to diagnoses, treatment plans, risk management plans of people who are involved in various settings in the hospitals or various court settings.

Q Let's turn now to the area of forensic evaluation. You indicated that you are actively involved in doing forensic evaluations. What sort of forensic evaluations do you do?

A I mean, I do -- I have been asked to do many cases pertaining to some sort of sexual violence. I mean, so in that context, I may end up doing evaluations where I'm asked to -- somebody, if they pose a danger to the community per the request, say, of an attorney. I am involved in -- have done a few SOR cases, meaning cases for the Sexual Offender Registry board. I've done cases for what we call in Massachusetts aid in sentencing assessments, have done competency to stand trial assessments, criminal responsibility assessments or the not guilty by reason of insanity assessment, and I have

been involved in a few custody related matters -- assistance type of assessments I have done and then have done a number of SDP or sexually dangerous person assessments or in the State of Massachusetts and outside of Massachusetts where they call it sometimes sexual violent predator type of assessments.

Q Specifically just related to your forensic evaluations, do you have an idea of how many of those you've done over the years?

A Forensic? Well, if I -- probably, again, I go with somewhat of a guess, but probably 500, 600 forensic assessments, if I'm not mistaken.

Q And you indicated that you have done it for various organizations. How many of those evaluations have you been retained by the prosecution or the petitioner to complete the evaluation?

A I mean, I --

Q And you -- percentages, not as a number. I know --

A Maybe it's easier for me -- the number because I have a lot for my cases in terms of the SDP cases. I -- as of probably last week, I was at, I believe, 380 cases for the prosecution and I -- take a guess. Sometimes I may be asked to assess somebody and I get back to the attorney, the defense attorney and say look,

I can't assist you on this matter. So I've been retained maybe on 17 cases for the defense and then ended up testifying maybe on 20 occasions and may have written reports on 40 occasions. So probably a total SVP/SDP related cases, I guess about 430, 440.

Q And it appears from your testimony that significantly more of those were for the prosecution or the petitioner than for the respondent or the defense.

A In terms of SDP cases, yes. I mean, for the prosecution, I'm asked -- I mean, various offices have asked me to do the assessment, but what I have been asked to do is to be almost like the gatekeeper to review records, for example, for the prosecution and based on the review of the records determine whether or not -- you go into a more in-depth assessment of the respondent.

Q And you indicated you prepare reports, that you have testified in court?

A Yeah.

Q You've been accepted as an expert in forensic evaluation previously in court testimony, correct?

A Yes.

MR. BELL: Your Honor, at this time, we would tender to The Court Doctor Saleh as an expert in the field of forensic psychiatry.

MR. GRAY: No objection, Your Honor.
THE COURT: Doctor Saleh is so recognized.
MR. BELL: Thank you, Your Honor.
BY MR. BELL:
Q Now, Doctor Saleh, in this particular case involving Mr. King, you were contacted and asked to conduct an evaluation by Mr. King, isn't that correct?
A Actually, I was asked by you to, yes.
Q And -- on behalf of Mr. King?
A Yes.
Q And in evaluating Mr. King, what exactly were you asked to do or what exactly did you do?
A Well, I was asked to answer a very specific question, the question of the sexual -- to determine whether or not he met the definition of a sexually dangerous person as defined by statute.
Q And in the process of conducting your evaluation, what did you do exactly?
A Well, I first of all tried -- not tried, because I was familiar with the statute, but I relooked at the statute and refamiliarized myself with the statute, but in the process of it, I reviewed thousands of pages of records over the course of the month, and this is -- actually recently listened to audiotape of a telephone conversation Mr. King had with his ex-wife and then also

came out to North Carolina and interviewed Mr. King at Butner.

Q Okay. And do you remember when the interview at Butner took place?

A If I could make reference to my report -- let's see. I came out -- it was in March of 2011. So I came out in March and met for about four and a half hours.

Q That was at the facility in Butner?

A That's correct.

Q Now, at the end of the evaluation, did you complete a report of some kind?

A Yes.

Q And did you provide that report to me?

A Yes, sir.

Q Would it assist you in your testimony today to be able to refer to that report as we go through your testimony?

A Yes. That would be of great help.

Q I'm going to refer you to what's been marked in the notebook -- I believe you have another copy -- as Respondent's Exhibit One. If you would, identify that for The Court.

A Yes. This is the report I wrote with regard to the questions you asked me to --

Q Now, with regard to your understanding of what

you were asked to do, explain to The Court, if you would, what your understanding of the definitions needed -- and the inquiry necessary to determine whether someone is a sexually dangerous person.

A Yes. Essentially what one has to do is -- at least that's my understanding of the statute is that there are three prongs. One is one has to determine whether the person in question, the respondent, if he has attempted or engaged in sexually violent conduct or child molestation and then also if he's a sexually dangerous person. And there's a definition of a sexually dangerous person, and the way I understand the definition to be, it essentially suggests that the person in question who has engaged in sexually violent conduct or child molestation, that they suffer from a serious mental illness, abnormality or disorder.

Then the third prong is one has to establish the nexus between the disorder or the serious illness they present with, if one were to determine that they present with that illness, and if they were to have serious difficulty refraining from sexually violent conduct or child molestation if released.

So it's a three prong approach, and that's what I did in this case. I looked at the statute, trying to understand the statute as best as I can, reviewed the

records and then tried then to apply the data I give it to the language of the statute where appropriate.

Q And after completing your evaluation of Mr. King and understanding the law as you just described it to The Court, did you reach an opinion to a reasonable degree of medical certainty whether Mr. King was a sexually dangerous person under the act?

A Yes, I did.

Q What was that opinion?

A It is my opinion to a reasonable degree of medical certainty that Mr. King is not a sexually dangerous person as defined by the statute.

Q Now, the Government has presented two experts in this case, a Doctor Zinik and a Doctor Graney, both of whom have opined that Mr. King suffered from a condition known as paraphilia not otherwise specified, nonconsent. Did you diagnose Mr. King with any sort of paraphilia?

A No, I did not.

Q Would you explain to The Court what a paraphilia is as you understand it and then your determination that he did not suffer from such a condition?

A Yes. Well, let's see. Where do you start out with? For somebody to suffer from paraphilia and -- start out with a more general description and then go to the very specifics -- one has to look at the person's

case history and their psychosexual development, and as -- I mean, it's described in the DSM-IV-T-R on page 522. It talks about a person, that he or she needs to present with recurrent and intense deviant sexual thoughts, fantasies or behaviors, and then it describes, for example, involving a nonconsenting person, a child and so forth, but the key is that the person has to present with these recurrent and intense sexually arousing thoughts, fantasies or behaviors and that it has to cause some sort of impairment for the person to meet the threshold criteria definition of a paraphilic disorder. In the absence of that, one can't diagnose somebody with a paraphilic disorder. So that's -- wanted the overall understanding of what a paraphilic disorder is.

Now, for -- and then you have various sub -- I mean, very specific paraphilic disorders as listed in the DSM. You have, for example, paraphilia. There are subtypes of paraphilia. You have sexual masochism. You have exhibitionism, which is important to discuss in this case. You may have the -- fetishism -- so there are various other types of paraphilic disorders that are described, defined and researched, and all of these conditions are based on research, scientific data that allows the -- me to ultimately say yes, there is such a

condition such as a pedophilia. As we say, there's a condition -- for schizophrenia -- we have enough evidence to support this diagnosis of, say, pedophilia or sexual masochism. So that's the overall requirement.

Now, the issue with Mr. King and the diagnosis he was given I think just by these two doctors, Doctor Zinik --

Q Well, Doctor Bazerman also diagnosed him with that.

A -- is that they used the labeling. That's not a diagnosis that is -- paraphilia NOS, nonconsent. And the key here is that it's nothing more than a label, because there is no such a diagnosis of paraphilia NOS, nonconsent. It's fictitious and ultimately made up, refuted by the field and not just by a handful of doctors who say well, we disagree with you in terms of the diagnosis, but the American Psychiatric Association, the American Academy of Psychiatry and the Law, even the criminal justice system refuted that diagnosis, not just in one meeting or two meetings but over decades.

And that's something that psychologists, a few handful of people try to introduce as a valid diagnosis, yet over now -- I think it would be almost three decades of ongoing debate, discussion and research that -- conclusion remain that there is no such diagnosis of

paraphilia NOS, nonconsent, and it carried different terms in the past.

I mean, paraphilic coercive disorder was one way people tried to describe it and introduce it as a valid diagnosis, so the problem with that is is that there is no empirical evidence behind it. There's no way that one could today describe this condition and compare it to some valid condition.

And the example I used recently is in medicine if I have a diagnosis like hypertension, for example, it's a valid diagnosis. I have criteria I have to meet to diagnose a person or a patient with hypertension, and then the importance of the diagnosis is it's not just that I say you have hypertension and now go home and live with your hypertension. There's an intervention that follows the hypertension many times, which may be introduction of medications, change of diet, exercise, and to ultimately accomplish a goal to treat and manage this condition you present with and lower your blood pressure. And with the paraphilic disorders, that's the same thing.

I mean, in my own clinic, I diagnose patients with paraphilic disorders, and not just because I like doing it or I have a good time and I want to throw out labels at people. There's a purpose behind it, because

the diagnosis and the differential diagnosis is followed by intervention and treatment, and that's why you have to go through a very careful analysis before you draw a conclusion that somebody suffers from a diagnosis such as a paraphilic disorder. And then that diagnosis is going to inform me, the treater, as to what intervention is needed, and so there is a purpose behind the diagnosis and a purpose behind the diagnosis in psychiatry and in medicine.

Now, if I could take this example of the hypertension and use this just really to juxtapose this to this paraphilia NOS, nonconsent issue -- is hypothetically let's say if I were to say today that I'm going to diagnose somebody with hypertension using a certain blood pressure cuff that has not been normed for the individual I have in front of me but it's just a blood pressure cuff and gives me a reading and I get a score and based on that score I'm going to say we have now -- and I arbitrarily then say then if you hit the number 160, you have hypertension and that now means that I'm going to treat you, if I were to do it as a physician and were to use that practice, I would be, I guess, in deep trouble if my patients were to get into harm's way and they were to have some medical problem because of the intervention I introduced that has no

basis, no foundation whatsoever.

The same is true with the paraphilia NOS, nonconsent diagnosis. There's no foundation behind it whatsoever. There's no research that guides me as to how to derive that conclusion and it's a made up diagnosis by a handful of psychologists, actually by -- Darwin was the first one who introduced this label for the purpose of commitment purposes, and then a couple of other psychologists followed suit and said well, yes, that's a good diagnosis and use different type -- of definitions to diagnose somebody with paraphilia NOS, nonconsent, for example.

If you said -- if you -- over six months if you end up raping somebody, say, twice, you may qualify for the diagnosis. So people started making up -- diagnosis for no good reason, and the problem with that is not only did I then have a label or use a label that is inappropriate to be used in a given setting, but then also the other problem is it's -- as far as I can say, it's the ethics behind it. In my judgment, it would be unethical to really diagnose somebody with something that doesn't exist and then use an intervention, whatever that may be, if I don't have a basis -- a condition like the paraphilia NOS, nonconsent -- has been refuted -- for me to take this step and say I

disregard it, I disregard these signs and I'm just going to use the diagnosis because I feel like it, I don't think it's -- at least it's not the way I would practice medicine or psychiatry, and I don't think it's appropriate to do so in any setting, clinical or forensic.

Q Now, you indicated that you didn't find that Mr. King suffered from any sort of paraphilia, whether it be paraphilia NOS, nonconsent label or a paraphilia of any type. If you would, explain to The Court how you arrived at that determination.

A Yes. It goes back to really understanding how to diagnose, and one -- ideas I have always been interested in actually since I went to medical school was proper diagnosis and proper assessment, because if I properly diagnose and understand the case, I can ultimately help the individual who is in front of me. I'm not talking about forensically, but in the clinical setting -- to help provide them with a better quality of life.

So in order to diagnose, you have to look at data, and the data -- ideally you would want them to be -- in psychiatry behavioral data, observations, descriptions of the behaviors that one can, I mean, read and say this is the way the person presented, these are the behaviors he engaged in and, therefore, I can

extrapolate by looking at the behavioral data and may draw some conclusions with regard to their mental state, their thoughts and fantasies they may have.

And with regard to, for example, paraphilia, it talks about the person presenting with these recurrent, intense deviant sexual thoughts, fantasies or behaviors involving sexual activity with a prepubescent child, so if I can establish that the person did indeed engage in sexual behaviors with a prepubescent child, even without knowing what they thought, felt, without knowing about their fantasies, I may be in a position to draw the conclusion that they do, indeed, suffer from pedophilia.

So the diagnosis, you look at behaviors, you look at thoughts and fantasies the person presents with, and then in certain cases, at least certain of my cases, even medical data may help me to draw conclusions with regard to diagnoses. And, again, sometimes the person may engage in a sexual offending behavior -- going to use pedophilia as an example, not because they suffer from this condition, pedophilia, because they have a tumor in their brain that ultimately caused them to engage in their behavior.

And we had cases where a patient may have had a growth in the brain, started to engage in problematic sexual behavior involving a child, and rather than

diagnosing that person with pedophilia, we did a study of the brain and saw that they have a growth in their brain and sent them to see a neurosurgeon. So you can draw conclusions with regard to diagnosis also by looking, for example, at a brain pathology.

Now, with regard to Mr. King, the reason why I didn't diagnose him with any paraphilic disorder is my assessment is not just based on speculation or made up diagnosis or thoughts I may have, gut feelings, but if I am data driven -- and I am data driven when it comes to diagnosis. I have to look through these records, and we talk about 2,000 plus pages of documents and what I heard from Mr. King and spoke -- where are the data, concrete data? I'm not big with the -- allowing me to draw the conclusion that this man suffers from paraphilic disorder, however you are to define it.

Now, what you have is -- in terms of data is -- we have one sexual offense he engaged in, and there is no discussion, no ambiguity about that when he was a juvenile. I believe at age 15 when he exposed himself to two children and they -- and my -- and no ambiguity -- it's very clear it's described as a sexual offense, but -- that he was found -- of a sexual offense, so that's one.

Then you have a subsequent offense which was, I

think, 15 months later when he got involved or committed a crime where he ended up fondling his victim's breast, and it's somewhat unclear what he did in terms of exposing behaviors. Some records say that he exposed his penis to this victim, and Mr. King's account is actually somewhat all over, but he at one point said he didn't expose his penis, didn't ask this victim to touch his penis, but there is no ambiguity with regard to the -- of the fondling of the breast of the victim at that time. So you have those two sets of data where I would say yes, there was some sexual offense, some sexually motivated behavior.

Now, subsequent to that -- and we talked now about a total of -- let me just quickly look at this. This would be at 33 years, I mean, or 34 years past, and for me to say that this man suffers from a diagnosis such as a paraphilic disorder, I would have to say well, where are the data for me to draw that conclusion. So I look at 34 years worth of records, and there are plenty of records on Mr. King, I have to say, and there's nothing in the records that would support a diagnosis of a paraphilic disorder at this time.

Now, this being said -- and that's why I think the approach, as far as I can say, the way one has to look at it, if I look at data, the question is how do I

define data and how do I understand data, the term data. As I said, it's observational, reports, official reports from authorities, say, police reports. That would be data points. And then you have, for example, in his case -- that's relevant is urine toxicology screens where you would see -- say use alcohol or drugs at various times, so that's a data point one has.

And then you have thoughts and fantasies -- again, thoughts and fantasies of the patient in front of me. I'm not saying that Mr. King is my patient, but in general, a patient can be relevant and quite enlightening because it may tell you what the patient feels, thought. It may help you understand the motivation behind a given behavior, and that's where you engage in treatment, because that's when they start talking about whatever is going on and they may help you draw conclusions with regard to a diagnosis.

The problem with Mr. King -- and I have to say was a difficult read. I mean, I had a difficult time to digest this set of records here -- is because he has been all over, across the board with regard to what he may have experienced, may have thought at one point in time.

And with all due respect to Mr. King, I mean, he has been described as being a pathological liar -- but

even if you disregard Doctor Zinik's report and description of Mr. King being a pathological liar, he has -- records dating back to the '70s, has been described as being a chronic liar, and I typically don't use the term chronic liar because it's pejorative, but in this case, it's tells you the story, tells you what to make out of what he said or didn't say to people over the course of 30 years. I can't rely on what he says. He may say something to me today I can't rely on, because I know that he has lied about the same topic maybe two weeks prior to my interview, and I can assume that he will lie about this three weeks down the road if he is interviewed by somebody else.

And if you look at the records and look at what he said and who he said caused the offending behaviors, I think it's really interesting here, because he has not just blamed drugs and alcohol for his offending behavior. At one point, he said well, it's drugs and alcohol. Then he said it's not drugs and alcohol, that he was free of drugs and alcohol, and he said he committed the offenses because he had blackouts. Then he said -- he didn't just say I had blackouts, but he also then said that an alter committed the offense while he had blackouts, so he's now avoiding responsibility, not just because he's claiming blackouts, but he's also

blaming the alter for his offenses.

Then at various other times, he was saying that he did commit the offenses and that it was sexually motivated without any evidence in front of me that would support that testimony. I mean, if I had that type of reporting, how can I rely on it and draw any conclusions with regard to a diagnosis -- I can't. It would be -- in my judgment, I would have to be shortsighted. I would have to be bias toward a given opinion to draw a conclusion with regard to -- diagnosis if I were to just rely on one set of data and disregard other data, meaning that if I select certain information out and say well, because I have -- opinion and objective to make the case, a given case, I'm just going to talk about this set of data, disregard others. Some people do it. I don't do it because I don't think that's scientific. I don't think it's appropriate, and I think it's really misleading if I were to do it, and because of that -- plus I don't have unambiguous data in support of a diagnosis. I said that nothing here in these records today would support the paraphilia diagnosis.

I know that during the deposition, the question I was asked was about what about the self-report that he was this hibernating bear who's going to come out and go and eat and kill and do all those type of things or his

report that all the behaviors are sexually motivated. Again, that's looking at it from one viewpoint, because I have then to juxtapose that same report to other things he said.

And one thing he also said that I can't disregard, because my objective is to be -- objective as possible, is his denial. I mean, several months later, he said look, whatever I said to people was false, I recant everything. How can I now say I'm going to disregard that report he's given to me that what he said was false and just give credence to what he said previously, that he is, indeed, going to go and kill and do those kind of things? You can't. I mean, that's just selecting things out and not being, I mean, I think objective with regard to the facts in front of us --

Q Was it important in your assessment of Mr. King to look at his behaviors after he was incarcerated as far as whether he had had any sexual type offenses or infractions while he was in the Bureau of Prisons?

A Absolutely. I mean, that's what you look at. I mean, if I hypothetically -- I certainly looked at this case from that viewpoint of -- Doctor Zinik's viewpoint. I don't know Doctor Zinik and -- but I said well, let me see if I can arrive at the same conclusion as he did, and now if -- to do that, what I have to do

is, again, I go back in time and say well, what is it -- talk about here and what did he say early on.

Mr. King, early on, he said he had a difficult time or inability to control his impulses and he was diagnosed at one point in time with exhibitionism, which is -- on its own, but let me just hypothetically say is -- that if I were to say that this man has, indeed, exhibitionism, which is a sexual disorder characterized by this recurrent and intense sexual thought of wanting to expose yourself to an unsuspecting person, even if I don't want to, I feel compelled to do it, why don't I see any evidence in 30 years of incarceration of exhibitionistic behavior?

I mean, it's not something that I can just turn on and off and say well, I'm going to just engage in this behavior when I'm in the community, but I'm not going to engage in these behaviors while I'm incarcerated, because, again, sexual disorders don't work like this. You have it or you don't have it or you suffer from it or you don't suffer from it.

If I now look at Mr. King's case, and hypothetically that's what I did -- retrospective, I looked at the case and said let me think about this exhibitionism diagnosis. If he had that condition, the argument for it would be that he did expose himself when

he was a juvenile. Again, if I even say I gave credence to what he said back then when he was a juvenile, that he did it on several occasions or several years, you could say that's somebody who's developing a sexual disorder called exhibitionism and he -- so hypothetically he had this condition.

Now, the argument against exhibitionism in the correctional setting is one could say well, he doesn't have victims. In Mr. King's case though, I couldn't make that argument, because he has said and has described himself as being homosexual or bisexual. I mean, that also has varied over the course of years, but he has reported and has had homosexual relationships, homosexual partners over the course of the years, so you could potentially say there are numerous victims out there in the DOC, not just other inmates, but also staff. I mean, there are female staff, male staff, and if he truly had this condition, exhibitionism, you would see something of it somewhere over 30 years.

And, again, knowing what I know about sexual disorders, and I have patients with true exhibitionism, it's not like they say well, I -- control it for 30 years. I mean, if you didn't engage in this behavior for 30 years, you don't have it, because there is no way that you could control it in that setting knowing what I

know about Mr. King, if he truly had that condition.

So the conclusion is he has had potential victims in the DOC, male, female. He has a sexual drive. It's not that you say that this man has no sexual drive or that he's asexual and chemically castrated. I mean, he has according -- I think Doctor Zinik said in his report a healthy sexual drive.

So we have a man with a healthy sexual drive in this setting where he is actually engaged in sexual relationships with other inmates, where he is procuring himself drugs right and left, yet he's not engaging in any type of sexual behaviors. That in my mind -- given what I know about this disorder in Mr. King's case, that's, for me, the conclusion that he can't have this condition, because, again, this is not a condition he can turn on and off at free will. That's for the exhibitionism.

In terms of the paraphilic disorder, again, hypothetically, let me just make -- again, look at this case from Doctor Zinik's viewpoint and say well, -- and I have to say that I really don't think there's any evidence in support of this fictitious diagnosis, and it's nothing more than a fictitious diagnosis, this paraphilia NOS, nonconsent condition, but hypothetically let's say Doctor Zinik is right and all the DSM,

thousands of other doctors and scientists are incorrect -- so Doctor Zinik is the one who prevails and other people don't, I need to have the data in terms of making this diagnosis.

Now, if -- again, hypothetically, if there were such a diagnosis of paraphilia NOS, nonconsent, what I have to establish as the clinician the, forensic psychiatrist that he -- this man, Mr. King, is sexually aroused to the nonconsenting aspect of the encounter, not just having rape thoughts or rape fantasies. The key is -- needs to be the nonconsenting aspect of the encounter between the victim and the perpetrator.

Again, looking through all these records, where is the data that would support that? I mean, I can't just say well, I believe he has that, because, otherwise, I can start out saying I believe many other people have many various conditions. It's not the way medicine works. It's not the way science works.

There's no data, no record entry in the records here that would unambiguously state and support the notion that he has this arousal on a recurrent basis resulting in some sort of arousal -- measured, say, by sexual -- to the sense -- to the nonconsenting aspect of the encounter.

Now, I believe Doctor Zinik and the other two

State examiners said well, we rely on his self-reports and this is what he told us on a given day when he was examined by us, and that's fine. I mean, they're certainly entitled to take that approach, but in my opinion, with all due respect to these good doctors, that's shortsighted. I mean, I can't just look at one set of reporting and say because this chronic liar said this to me on this given day, now I'm going to run with this and make this a diagnosis because he said it.

What would I say if he were to tell me today that he's a Martian? Would I say well, you're a Martian, now I have to provide you with a treatment because you're a Martian, or if you report that you hear voices, I'm going to throw antipsychotics at you? That's not the way we would practice medicine or diagnose and prescribe medications.

You have to look at the totality of the data in the database, and the database are the thousands of records we have and the descriptions he has received. I mean, he had underwent -- psychological assessment and did the MMPI, which is a way to assess personality disorders, and he was said -- as being a bad faker of psychopathology. He was described by people who had nothing to do with the current court proceedings -- who described him as being a manipulative liar. How can I

rely on this man's report if that's who he is, who he is presently and how he was described for 30 plus years? I mean, it would be, again, impossible. So I have -- in my judgment to dismiss the self-reporting that -- I have to look at some other evidence.

So you have then the 1993 incident report where he, again, asked the therapist or some staff to touch his penis, but asking somebody to touch his penis is not the same as to say that I have these recurrent intense deviant sexual thoughts of having thoughts of nonconsenting activities. I mean, he asked, and you would say it's even appropriate. He asked. He was -- said no, that this person is not going to have sex with him or touch his penis, and that was the end of the story. That's not basis or evidence for a sexual disorder whatsoever.

THE COURT: Well, Doctor, if that occurred -- if that type of incident, the 1993 incident requesting staff to touch his penis, if that occurred with more frequency, would that then be evidence that he was having these urges or fantasies?

THE WITNESS: What this would tell me is that he has a sexual desire, but that wouldn't tell me that it's a paraphilic desire, because I have also to consider that he is institutionalized. I mean, he has

been in institutions for most of his adult life, as far as I can say, so that would be -- at that juncture, with just that description, I would say that's institutionalized behavior.

For me to draw the conclusion and establish the nexus that this behavior is tantamount to a paraphilic phenomena, I have to establish that that is, again, recurrent, intense and it's paraphilic in nature. Asking somebody, even staff, to -- even to have sex with a person is not necessarily a sign of a paraphilic disorder. It could be just a disregard he may have for the role the staff person has and not understanding that he is an inmate and the other person is staff and that he has to respect that boundary.

THE COURT: I want to make sure I understand your view on, as you put it, the fictitious nature of paraphilic NOS, nonconsent diagnosis. Am I understanding correctly that you're saying that there's no scientific evidence showing that a person would actually be sexually aroused by the nonconsent aspect of an encounter of that nature?

THE WITNESS: Given what we have today at our disposition, there's no empirical evidence for us, meaning scientists and forensic psychiatrists working with this population, to say that we have empirical

evidence to establish and introduce this diagnosis. So the answer would be affirmative, there is no evidence to support it.

THE COURT: So there's no evidence showing that a person would actually be sexually aroused by the nonconsent aspect of a sexual encounter of the type that we have here?

THE WITNESS: There's no evidence that -- no evidence that made it to a diagnosis. I mean, did people at times report that they get sexually excited by the nonconsenting aspect of a sexual encounter? They may have, but that is not sufficient for the signs for the -- to take the next step which is to say that that's enough evidence, enough data for us to say that there is such a condition like a paraphilia NOS, nonconsent diagnosis.

THE COURT: Okay. Thank you. Mr. Bell?

BY MR. BELL:

Q We were talking about -- I think the judge -- might have missed his question a little bit. I think the question was if as opposed to there just being this one incident in 1993 where he made this sexual proposal to a staffer, if it had happened over and over and over again, you know, ten times a year, 12 times a year where you had documented evidence in the record of these --

over and over doing this sort of thing, would that potentially have had an impact on your decision or your determination whether or not Mr. King had some sort of paraphilia?

A I mean, I certainly -- if he had, say, a situation where, as you pointed out -- and I apologize. I may have misunderstood you, but, say, he would have numerous episodes of similar behaviors of soliciting staff -- despite numerous requests not to do so so that he would request over and over sexual touching type of behaviors, there could be a paraphilic disorder.

There is one which has been described which is called toucherism, actually, and it's slightly different than frotteurism because frotteurism involves rubbing and touching. Toucherism just involves the touch -- you might think.

I had one patient who presented with toucherism, and he would get excited by somebody touching him, and it could be any body part that would then cause arousal and excitement, and my fellows who would come to my clinic, I would always tell them not to shake people's hands even if they're asked to shake them because they may have a condition called toucherism. And whenever this patient was there, he would ask other fellows to shake their hands, not because he was just a polite guy,

but he would get something out of it, which was sexual arousal and excitement.

So the answer would be affirmative, if I have somebody who is requesting to be touched numerous times, that could be certainly -- that could be some evidence in support of a paraphilic disorder such as toucherism.

Q So your testimony would be that it's important in the sense that it's absent in the records, and it -- would it be equally important if it were present in the record?

A I mean, there's nothing in the records other than the 1993 incident as far as I can say where he tried to solicit somebody or ask somebody to be touched, but then even if he had these numerous episodes, one has to go -- then go and take the one next step and understand in what context that this behavior -- occur. What is he trying to get out of it? It could be just for attention because he wants to just annoy the other person and he wants to -- or it can be also because he gets sexual arousal out of it by being touched.

Q Okay. Doctor Zinik in his testimony also testified or diagnosed -- and we talked about the exhibitionism diagnosis, but he also diagnosed Mr. King with polysubstance dependence. That was not a diagnosis that you made. Would you explain to The Court why you

did not make that diagnosis?

A Well, again, I go by data. I mean, I did agree and understand that Mr. King did engage in substance abuse, and he certainly has a longstanding history of substance abuse. Again, depends -- in terms of the longstanding -- depends what records one -- but I -- at least based on the records, he has engaged in substance abuse. He has done drugs while incarcerated. His urine toxicology screens tested positive at various times, most recently I believe in 2009.

So one is he has abused drugs, but abusing drugs doesn't mean that I'm dependent on it. That's, again, where I think -- where I'm -- my approach is to be more careful with a diagnosis before I say somebody is dependent on a substance. I have to establish that, and for me to establish that there is dependency, the DSM requires that the person has to present signs and symptoms of withdrawal or tolerance.

Again, looking at these records, where is the evidence of tolerance and withdrawal? I mean, I haven't seen anything in the records that would again unambiguously state that he has experienced tolerance and withdrawal to substances, so I -- again, I not -- this diagnosis, just saying well, that fits the bill here and let me use polysubstance dependence.

He has engaged in substance abuse, yes, but there's no evidence to suggest that he became tolerant to -- substance or that he withdrew from a substance. And, again, in the absence of data, I'm not diagnosing him with polysubstance dependence.

Q Is it important to you that -- there was some testimony from both of the experts, government experts earlier in the week related to -- you know, there was the one incident in 1993 with the female staffer, there weren't any other incidents, and there was some testimony related to the penal setting and that being -- having an impact on Mr. King's acting out or being afraid about getting in trouble and that sort of thing.

Is it important to you in your assessment of Mr. King that he did, in fact, get in trouble over and over again for, as an example, testing positive for drugs and that sort of thing, but, again, there was no disciplinary infractions or anything for -- of a sexual nature? Was that important to you?

A I mean, absolutely. I mean, the point is if -- and that's, again, the way I think one has to look at this case is not just to pick certain pieces of information, but look at the entire picture. And what I always try to do is to really get an understanding of the big picture rather than being lost in the detail and

then drawing erroneous conclusions.

If I have somebody who says look, I care about how I do -- I want to behave, I don't want to get in trouble, and if that's their mindset and that's absolutely something -- you would say that's great. That's what hopefully a penal setting -- you would want them to go through is we have -- understanding that proper behaviors are -- expect of you, you have to adhere to the rules and regulations.

So if that's the mindset that you -- report and the objective and, therefore, I -- and, if, again, say that that's true, that's the mindset and that's the reason why he didn't engage in sexual behaviors or acting out behaviors and -- sexual wise, how do I explain then all the substance abuse and the drug seeking behaviors and the positive urine toxicology screen? Specifically if I don't have somebody who is dependent on a drug, how can I explain? It just means that he doesn't care, because if he truly would care about the rules and regulations, he would make sure not to do drugs, to sneak in drugs and use even heroin in a penal setting.

That's, again, where you can't pick and choose, so that's -- if I look at the totality of the behavior, I see that there has been acting out behavior, even --

probation -- I mean, if I go to see a psychiatrist and I make up the story of I have an alter who talks to me or that's the alter talking to me and it's not me or I hear a voice, yet the evidence later on showed us that he never heard voices or experienced true hallucinations, that's abusing the system. That's manipulating the system to get some ulterior motive met, but that's not good behavior, somebody who is trying to do his best and be real obedient.

Q Now, you did make a diagnosis in Mr. King's case. Talk to The Court about what diagnosis you did make.

A I mean, the only diagnosis that I thought for which I had evidence was the antisocial personality disorder. I mean, there's plenty of evidence --

Q Well, first explain to The Court what antisocial personality disorder is.

A So antisocial personality disorder is a diagnosis that is listed as one of the personality disorders in the DSM-IV-T-R, and what it requires is enduring a pervasive pattern, and that's really important with personality disorders -- enduring a pervasive pattern of ultimate antisocial behaviors.

And in his case, Mr. King's case, the signs of behaviors engaged in that would support that is as a

juvenile he would, in my judgment, satisfy the conduct disorder diagnosis because that's Criteria C of the diagnosis that you have to meet before you actually even endeavor and give somebody the antisocial personality disorder diagnosis -- you have to establish that they do meet conduct disorder as a diagnosis prior to the age of 15, and he does, based on the records. That's one.

And then there are characteristics of antisocial personality disorder. One in his case is irresponsibility. Has he been a responsible citizen in the community or out in the penal setting? In my judgment, he has not been a responsible person because he's manipulating everybody left and right and is engaging in all these maladaptive behaviors in the penal setting, so I couldn't say that he has been a responsible person.

And along those same lines, he has been conning people. He has been deceitful for years. I mean, all those traits would support -- and because they are persistent, pervasive, they have lasted for 30 plus years now, that's why -- opined that he meets the definition of antisocial -- of antisocial personality disorder as defined by the DSM-IV-T-R.

Q Now, there was some testimony earlier in the week from the Government's experts related to -- well,

first, there was the diagnosis of the paraphilia NOS, nonconsent, and then there was some risk assessment done of Mr. King related to whether or not he would reoffend. You did not do any sort of risk assessment in your evaluation of Mr. King. Explain to The Court why you didn't do that.

A Well, because there -- it actually doesn't ask for it. I mean, the statute is very -- I mean, the statute is unambiguous. I mean, it says I have three prongs I have to look at. One is the first -- what I look at, did this person engage or attempt to engage in sexually violent conduct or child molestation. That's one.

Then I have to determine whether or not he is suffering from a serious mental illness, disorder or abnormality -- with the -- order but that he has this serious mental illness or abnormality or disorder, and in his case, he doesn't have that disorder, and there's no room in the statute that says disregard what you just said, that he doesn't have this disorder, still go ahead and do the risk analysis, because I think it's very clear because it says -- means the person is suffering from this condition and as a result of which -- so there's a nexus that needs to be established -- he's going to have serious difficulty in refraining from. So

if I can't establish the nexus because I lack that element, for me to go beyond it would be, I think, even inappropriate because the statute is not asking for it, and because of that, I didn't go and do a risk assessment.

Q Now, you do have cases where you do do risk assessments, isn't that correct?

A Absolutely, yes.

Q Explain to The Court, if you would, when you do a risk assessment in a particular evaluation what process you go through.

MR. GRAY: Your Honor, at this time, we would object to this answer. He's already testified that he did not do a risk assessment. Therefore, the contents of what he would do in a risk assessment seems to be irrelevant at this point in time.

THE COURT: Well, I don't think it's irrelevant, given the fact that the experts proffered by the Government did do risk assessments, so I'm interested in hearing the doctor's opinions in this area. The objection is overruled. Mr. Bell?

A So the issue is that, first of all, I do risk assessments where appropriate and where indicated, and what I do is I do it as a forensic psychiatrist and as a treating doctor. I'm data driven, and I'm not trying to

present data if it's to a fellow colleague or to the trier of fact in a way to mislead the other party but to inform them.

And even if I'm retained by defense counsel, the objective at least I have in my mind is not to be an advocate for the respondent but the advocate of the opinion and be presenting it as objectively as I can.

So what I don't do is I'm not misleading, and that's relevant in this case and in any other case, because if you look at the risk assessment tools that have been used -- and I'm certainly a supporter of the idea that you want to improve the accuracy of our predictions. You want to maximize it as much as we can, because if you're content with second best, we may never be able to accomplish the ultimate goal to ultimately help the trier of fact to understand the person's risk and also to help ultimately the respondent so that they don't get in trouble.

With regard to the risk assessment tools that are available, people rely on the actuarial risk assessment tools, and one of them is -- that has been widely published is the Static-99, and then there are progenies from the Static-99 that developed like the Static-99R or Revised, the Stable 2007, MNSOST and now as of recent Thorton's New Structured Risk assessment I

think Guide or Tool, Forensic Version. I mean, that's -- I may be wrong with the acronyms there. I think they're interesting tools and important in terms of signs that we want to try to capture data and draw conclusions.

The problem with them is -- and why I think it's actually dangerous and -- is they call themselves -- as being actuarial instruments, and that as far as I understand the term suggests objectivity scoring, analysis and it's not allowing room for any subjective opinion, thoughts, impressions, and that was the original approach.

And the idea with the Static-99 was it was supposed to be a screening tool. It was supposed to be used by anybody without even a -- I don't know if it's college degree, but no postdoctoral fellow type of degrees or master's degree or so forth, but, for example, a probation officer could just use that instrument and based on that say that person's risk is such.

So entering the data, entering the numbers, getting the total score and then based on the score saying his risk to offend is low, moderate low, moderate, moderate high or high, and the maximum would be six and whatever would exceed that total store of six, there are ten items on the Static-99 -- he would

still fall in the high risk category to recidivate sexually over that -- initially it was over three time periods, five years, ten years, 15 years. Very simple, made sense, but then what happened -- and that's how science works.

There was an evolution to it, more data, more understanding, more learning and discussion about these risk assessment tools, and what many people found out is is that the norms that they would use to create these samples and these scores were outdated. They were outdated by decades. Therefore, they introduced new norms in 2008 or so.

So there was a very brief period of time that that were new norms introduced, and shortly thereafter, people started to say well, look, what about the age factor here? People -- getting older, their risk to recidivate decreases, and that's something that is and has been known, that sex offenders' risks -- specifically if they're rapists or extrafamilial child molesters, that their risk to recidivate decreases over time with them getting older.

Again, even if I take -- one step beyond the recidivism studies and look at the physiology of sexual drive and sexual functioning, it makes sense, because I do know that male sex hormones, testosterone and

dihydrotestosterone declines with the aging process and people don't have the same sexual drive as they used -- when they were adolescents, so there's even a physiological correlate to this notion that age is going to have an impact on a person's risk to recidivate.

So the Static-99R or Revised was introduced to look at the age factor more critically, and so rather than saying that if you are below 25, you're at greater risk of -- compared when if you're above 25, it's broken down in four age categories, as far as I remember, or three age categories, so subtracting numbers if you get older from the total score -- and that's still fine, but then what happened is -- and that's where I think the problem is.

The evaluator was then asked to look at cohort data. When we look at the Static-99, MNSOST, Static-99R, it's not that that's specifically designed for the individual in question. It's a core of sex offenders and the data -- scores the percentiles are based on that score.

Now, I as the evaluator am now asked to look at the data, look then at my client, the respondent, and I have to make the determination whether or not the respondent falls into -- there are four different categories, subcategories that were then introduced, and

I have to make the determination if he is a routine sample type of -- or if he would be more fitting into the core of people who are called -- to be routine sex offenders, high risk offenders, treatment offenders and so forth.

So what happens is that I'm as the evaluator asked to make a subjective determination and determine whether or not he falls into one core or the other, and that's a problem. I mean, I can't -- it goes back to what I said earlier about the diagnosis. I can't have it both ways or I have to say that this is the best we have, it's out of moderate predictive accuracy -- in terms of risk recidivism, that's the best we have, and there is subjectivity involved.

That would be a honest description of the risk assessment tool, but if I call -- objective assessment tool, it's actuarial, yet there is subjectivity involved, and if I present -- to the trier of fact and say look, this guy or this respondent scored this number and I then use all these scientific terms and numbers, what I do is I, in my opinion, may mislead the trier of fact because I'm presenting to them something that gets you the -- of science, yet there is no -- I mean, there is no science behind it because there is subjectivity involved. So that's why I stay away from them at this

point in time when I use actuarial risk assessment tools -- and, again, I use them. I just look at the items because the items are important. They have been validated, but I don't correlate the number I get to a risk category, and I'm not saying that his relative risk is this over this time period or over the percentile ranking. I don't go into the -- I don't think that one has been fully flushed out. I think it's misleading and it's a risk of presenting something to the court that could be misinterpreted, and I think that's, again, in my judgment, inappropriate and that's not the way we would do medicine.

Again, the example I used earlier with the blood pressure cuff, if I were to say that you have this core of people who have high blood pressures and you have to come up with something to treat this group of people with high blood pressures and I say well, this is the best we have, one blood pressure cuff for everybody, and I use it on somebody who is morbidly obese, on somebody who has, say, my height and muscle mass and a child and -- I would get on all those three people the score, because if I put it around my upper arm, I will get a score and I will get a number, but will I go and act on that number and score and say well, this person has hypertension because of that score and I'm going to put

him on this -- medication and treat hypertension? Absolutely not, because if I were to do it and I would kill the patient, I would be in trouble, because, again, that's not the way medicine would work, but that's the way sexual risk predictions work at this point in time and that's why I stay away from using the actuarial risk assessment tools.

The instrument Thorton has used, same thing. I mean, it's interesting to look at, but it has not been peer reviewed. It has not been looked at carefully enough. We don't know even if it's appropriate to be used in a case like Mr. King's.

So as -- I certainly am not objecting to new instruments, new tools, but going then into court and rendering opinions to a reasonable degree of medical certainty or professional certainty based on assessment tools that have not been validated, I think it's dangerous terrain, and in my judgment, given what is at stake, I think it's really almost unethical to go that route at this point in time because you can't mislead people. You can't mislead the trier of fact with what we have and all this --

Q Doctor Saleh, I'm going to wrap up and ask you the last questions I have. Do you have an opinion to a reasonable degree of medical certainty whether Daniel

King had engaged in or attempted to engage in sexually violent conduct or child molestation?
A Yes, I do.
Q What is that opinion?
A Well, I'll tell you this. The opinion is that he certainly has been and was convicted of sexual offense as a juvenile, and you have this incident offense that followed two years after, I believe in '78, where he fondled, molested this victim's breast. For whatever that is worth, I mean, I would say that that would satisfy in my mind the first prong of the statute, yes.
Q And do you have an opinion to a reasonable degree of medical certainty as to whether Mr. King suffers from a serious mental illness, abnormality or disorder as a result of which he would have serious difficulty in refraining from sexually violent conduct or child molestation if released?
A Yes, I do.
Q And what is that opinion?
A As I stated previously, the opinion is that there's no evidence in front of me today to suggest that he suffers from a statutorily defined serious mental illness, disorder or abnormality, and that's -- there's no evidence in support of it.
Q And do you have an opinion to a reasonable

degree of medical certainty as to whether Mr. King is a sexually dangerous person under 18 USC 4248?

A Yes.

Q What is that opinion?

A Again, as state -- in the absence of data allowing me to establish a second prong of the statute, the opinion is that he is not a sexually dangerous person as the statute defines a sexually dangerous person at this point in time.

MR. BELL: Your Honor, that would be all of our questions.

THE COURT: Very good. Thank you. Let's take our morning break. We'll reconvene at 10:45.

(Whereupon off the record.)

THE COURT: The Government may cross -- oh. Doctor, could you please resume the stand, sir? Counsel for the Government, any cross-examination of Doctor Saleh at this time?

MR. GRAY: Yes, Your Honor. Thank you.

EXAMINATION

BY MR. GRAY:

Q Good morning, Doctor Saleh.

A Hello.

MR. GRAY: Your Honor, with the permission of The Court, if it's all right if I stand, I'm vertically

challenged and I'm having a little trouble seeing over the monitor.

THE COURT: That's fine.

MR. GRAY: Thank you. I appreciate your indulgence.

BY MR. GRAY:

Q Good morning, Doctor Saleh.

A Good morning.

Q Doctor Saleh, I'd like to start off by talking a little bit about your background. You mentioned you had testified as or acted as a gatekeeper for government entities in the past with regard to evaluations of sexually dangerous persons, isn't that right?

A Gatekeeper, yes, that's the term I used. I did screening assessments.

Q And you testified earlier that you had testified roughly 70 percent for the government and 30 percent for the respondent. However, in your deposition, you testified that you had testified 70 percent for the respondent and about 30 percent for the government.

A Actually, if I said it, it would be -- I misspoke. I didn't testify -- the screening assessments I have done didn't require testimony.

Q And I think it was that -- how many evaluations have you done on behalf of the respondent versus the

government, and you said probably 60 to 70 percent, and then, okay, with regard to the other 30 to 40 percent, would you be working for -- on behalf of the government or the community or the Commonwealth of Massachusetts, and you replied that's right. Does that sound about familiar? That's from page 19 of your deposition.

A Could you just repeat it? You're going too fast.

Q Sure.

THE COURT: And if it would assist -- Your Honor, if I could, I could place that on the monitor to assist the witness.

A Can you just read it? Whatever you like.

Q Okay. Sure. How many of those 400 were on behalf of the respondent versus the government? Your answer, I have to say -- I have to take a guess here, but I would say 60 -- probably 60 to 70 percent. Okay. And with -- the question was okay, and with regard to the other 30 to 40 percent, would you be working on behalf of the Government For the Commonwealth of Massachusetts, and your answer is that's right.

A Let me then clarify. What I do is in Massachusetts I'm asked by both the Commonwealth or defense attorneys to look at the SVP cases. Now, for the government, I have done, as far as I recall, about 380

screening cases, and I probably get one or two cases per week referred to do a screening assessment. And then I have been asked by various defense attorneys over the course of the years to assess their client or review records. This is not just in Massachusetts but outside of Massachusetts. And, there again, I'm going by a guess. I may have been asked 50 to 60 times to look at somebody's case and then may have written a report 30 times or 20, 30 times.

And then typically when I write a report for the defense, I end up testifying -- there may have been a few occasions where I wrote the report and then the respondent withdrew or -- I mean, I was then asked not to testify -- one occasion I know that the respondent didn't want to go forward.

Q So, Doctor Saleh, would it be fair to say that you work more for the respondent than you have for the government?

A I don't think so. I mean, if you look at the numbers, if you have 380 cases for the Commonwealth and I have, say, 60, 70 or take -- even make it 100 cases for the respondent, I think the way I would look at the numbers here is even if they're not 100 percent accurate is that I would have done more work for the Commonwealth and a quarter of that work I have -- the percentages

I've done for the defense, respondent.
Q Okay. So I guess the testimony at the deposition, you misspoke?
A It's possible, absolutely, yeah.
Q Now, Doctor Saleh, you are a psychiatrist?
A I'm a psychiatrist, that's correct.
Q And as a psychiatrist, you're a medical doctor?
A Correct. That's correct, yes.
Q And as a medical doctor, you can prescribe medications, correct?
A That's correct.
Q And, in fact, you testified that you're Board certified, correct?
A That's correct.
Q And you also testified earlier that you're a member of the American Psychiatric Association, correct?
A That's correct, yes.
Q And you're a member in good standing with the APA, correct?
A Yes.
Q And you continue to do continuing education, correct?
A Yes, true.
Q In fact, you probably attended a few of the APA conferences, correct?

A No, that's not -- I mean, APA sponsored conferences, yes.
Q And you're familiar with what -- the policies and bylaws of the APA, correct?
A I'm not sure if I'm familiar with them. I never read them, as far as I can say.
Q But you're aware that the APA has certain policies and -- that it represents on behalf of its members, correct?
A It probably does, yes.
Q And you are aware that the APA had a taskforce when it came to the evaluation of sexual offenders, weren't you?
A When? At what point in time?
Q The APA had its taskforce which published its findings in 2005.
A Yes. I mean, I don't remember, but that's true. I mean, probably that's true.
Q And you're aware that the APA has made it a policy that it has fought to repeal sexual dangerous person statutes?
A I think there was a -- as far as I recall, right, that spoke to that issue.
Q In fact, the APA has also said that its opinion is that psychiatry must vigorously oppose these statutes

in order to preserve the moral authority of the profession and to ensure continuing societal confidence in the medical model of civil commitment. Are you aware of that?

A You're reading it, so I assume that's correct, but I'm aware of the language similar to what you just said, yes.

Q And that the APA has also come to the opinion that sexual predator commitment laws represent a serious assault on the integrity of psychiatry, particularly with regard to defining mental illness and clinical conditions for compulsory treatment.

A Well, it depends, because it goes back to what I said earlier is that -- depends how you go about that work. I mean, if you do it unethically and you don't adhere to the requisite standards of medicine, you have a problem, but if you adhere to -- and, again, the issue is you adhere to the medical principles and then you apply the information you gather through the adherence of the medical principles to that statute, as long as you -- ethically, I don't see that to be a problem.

Q And the opinion of the American Psychiatric Association is that it creates an ethical dilemma for psychiatrists to opine as to the sexual dangerousness of a person?

A Again, it depends how you do it. I testified just two weeks ago, three weeks ago in Washington State on a matter, and there I would agree. I mean what I saw, I thought it was horrendous, inappropriate use and inappropriate testimony, but there are psychiatrists, psychologists who adhere to ethical standards and there are psychiatrists and psychologists who don't.
Q And, Doctor Saleh, you came to a diagnosis in the case of Mr. King, isn't that correct?
A A clinical diagnosis, that's correct.
Q And that diagnosis was that you found him to suffer from antisocial personality disorder, isn't that correct?
A That he presents with a history of antisocial personality disorder.
Q And as he presents with a history of antisocial personality disorder, you made that as a diagnosis that he currently has, isn't that correct?
A That he meets diagnostic criteria as defined in the DSM-IV-T-R for that condition, that's correct.
Q And finding that he meets the diagnostic criteria as found within the DSM-IV-T-R -- you used the DSM-IV-T-R in order to help make your diagnosis, isn't that right?
A Well, it's not helped me make the diagnosis.

There are the ICD, for example, and there are various other -- I mean, the ICD and the DSM-IV-T-R, those are the two references one uses to draw conclusions with regard to one phenomenology and, secondly, with regard to diagnostic -- or syndromes, people may present with or not -- may not present with.

Q So as a psychiatrist, you rely on the DSM-IV-T-R?

A I do rely on the DSM-IV-T-R.

Q And other psychiatrists rely on the DSM-IV-T-R, correct?

A Depends. As I told you just a second ago, two weeks ago, the psychiatrist who testified didn't rely on the DSM-IV-T-R and he used a diagnosis that doesn't exist, and so there are psychiatrists who do adhere to the standards and others who don't.

Q And you think that the use of the DSM-IV-T-R and its criteria that help make -- diagnosis, that's adhering to the standards, correct?

A Not necessarily, because it really goes back to the issue of science and scientific basis for a condition, and the primary principle is the scientific foundation behind the condition that may be described in the DSM-IV-T-R or any of the DSMs, and that's, I think, the primary objective one has to have -- has to have is

not just to say well, I go with the diagnosis because it's defined in the DSM-IV-T-R and I just go through the criteria.

I, as a independent evaluator, also have to look into the symptoms the person is reporting to me and determine whether or not this report is -- report of this symptom, if that's, indeed, one, accurate with the understanding of how symptoms manifest themselves over time in a given individual and if it's also consistent with the natural course of the disorder.

To give you an example, hyperactivity is a symptom you see, for example, in the context of attention deficit hyperactivity disorder, so if I were to say well, I have somebody with hyperactivity and they are fidgety and, therefore, I draw the conclusion and say it's in the DSM-IV-T-R, hyperactivity, and the patient in front of me has ADHD, attention deficit disorder -- hyperactivity disorder, combined type because he's hyperactive, that would be a very simplistic non-scientific approach to diagnosis.

What I have to do as a clinician is to determine in what context does this hyperactivity occur. If you look at me, I'm slightly moving on my chair and may be described by you maybe as slightly fidgety. Do I have ADHD? I can assure you I don't have ADHD, but somebody

with a simplistic view of -- diagnosis could come across and say look, Doctor Saleh is moving in his chair, appears to be slightly hyperactive, therefore, he has ADHD and now also let's put him on Ritalin to treat his ADHD. That would be inappropriate use of the DSM, inappropriate use of understanding the foundation behind the diagnosis and treatments.

Q And I appreciate your answer, but my question was with regard to Mr. King, did you use the DSM-IV-T-R?

A Actually, I do think I did answer your question. I said it -- in my report that the diagnosis I gave him, the antisocial personality disorder is as defined in the DSM-IV-T-R.

Q So that's a yes?

A Well, it was a long worded yes, yes.

Q Thank you. And with regard to Mr. King, did you use any other references in order to help make your diagnosis of Mr. King?

A Well, I'm not sure if you're referring now to the antisocial personality disorder, other references to make that diagnosis.

Q Well, I'm just asking what additional references did you use in order to make the diagnosis you testified quite lengthy that you used in the DSM-IV-T-R?

A I'm not sure --

Q Did you use any other references such as the DSM-IV-T-R to diagnose Mr. King?
A I mean, that's where I'm suddenly confused. If I used the DSM-IV-T-R to diagnose him with antisocial personality disorder, what other references are you referring to if you say did you use other references? Because if I used that as the reference -- maybe if I understand, your question is did I look at other literature pertaining to antisocial personality disorder to draw the conclusion that this presentation is consistent with the description of antisocial personality disorder as described in the DSM-IV-T-R? The answer would be affirmative.
Q No. My question was were there any other references, and it sounds like your answer was no. Would that be a fair characterization?
A I'm not sure if I understand what you mean with other references, because if I use -- because, again, -- more you use one reference to diagnose or I could -- I mean, if I understand you correctly, I could have used the ICD to diagnose him with a personality disorder. I didn't do that.
Q So you only used the DSM-IV-T-R?
A Yes. I mean, that's what I said in my report.
Q And, Doctor Saleh, with regard to the diagnosis

under the DSM-IV-T-R, you testified earlier that it's important as a clinician to not pick and choose, isn't that right?

A It's important to look at the database in front of you, understand the database and then draw conclusions that are consistent with clinical information in front of you. You can't be selecting information in and out with regard to a given diagnosis.

Q And with regard to the database that you used, you have several thousands of pages of medical records spanning a 34 year period, isn't that right?

A That's correct.

Q Now, Doctor Saleh, ultimately one of your conclusions was that due to the fact that Mr. King is, as you described him, a chronic liar, that made a lot of the data that you used unusable?

A -- I'm not sure, because it's not unusable. It's still usable, because you're able to draw -- I mean, you're still able to draw conclusions. It's not like I discard that information. Malingering, for example, is a phenomenon or a construct that is described in the DSM-IV-T-R, and so it's not unusable. It helps me understand the case, this case and concepts around malingering.

The other issue is, for example, when he talks

about alters, I don't just discard it and throw it into the garbage bin and say because it's his report, I discard it. Again, as I said earlier, I looked at it. Even if I at the end concluded that his self-report is not reliable so that he's not a credible person, I -- rely on what he says to draw conclusions to a reasonable degree of medical certainty with regard to a diagnosis. I certainly wouldn't want to say it's just not unusable.

Q And then taking a look at the data, you had to make an evaluation as to whether or not the data that came from Mr. King in particular was credible or not, is that right?

A I mean, the thing is you look at the reliability of the information, and the example would be the issue of, again, I see social workers and psychologists and even psychiatrists sometimes say the patient told me he is hearing voices, therefore, he has schizophrenia, let's put him on Haldol. That's what I see many times, and when I do the IMEs, independent medical examinations, that's what I'm asked to look into is what's the basis behind their approach, their diagnosis and treatment.

So if I go with a report and the self-report is I hear voices, it would be extremely simplistic for me to take it at face value and say yes, you hear voices,

therefore, you have schizophrenia. The clinician or physician, they have to take a step back and do an analysis of the symptoms they're hearing about that is reported and determine whether or not that is true -- first of all, a true symptom, so an idiopathic presentation of the -- the phenomenon and then in what context does this occur.

And so with Mr. King, he has made various claims about alters, voices, different moods, being suicidal, not suicidal, self-injurious, not self-injurious, take whatever -- I mean, actually, I look through the diagnosis and it's a list of everything you have in the DSM he -- carry as a diagnosis, and that tells you always something,

I mean, he told people many things over the course of the years, and people at times said well, given what they have, that's the diagnosis, and they diagnose him with it. The advantage I have is -- over what other doctors did at those times is I have had the opportunity to review 3,000 pages of records and put things back into context.

And given the fact that he is not carrying any of the above diagnoses, he doesn't carry a diagnosis of dissociative personality disorder, he doesn't carry a diagnosis of schizoid personality disorder, he doesn't

carry a diagnosis of schizophrenia, he doesn't carry a diagnosis of atypical psychosis, he doesn't carry a diagnosis of anxiety disorder, he doesn't carry a diagnosis of intermittent explosive disorder and so forth -- and the list is much longer than what I'm telling you -- that tells you something about him and his reporting and his presentation, that whatever he may have said at one point in time to somebody may have shown not to be accurate and not valid to justify a clinical diagnosis and a treatment, because he's also on no psychiatric medications.

Q Doctor Saleh, I'll ask this question again in a very simple way.

THE COURT: Mr. Gray, let me interrupt you. I want to make sure I understand, Doctor Saleh. When you say that Mr. King doesn't carry a diagnosis, what do you mean by that, sir?

THE WITNESS: I mean the point is if you look into the records, he has carried every diagnosis one can think of.

THE COURT: Does that mean that at some point somebody has diagnosed him with that?

THE WITNESS: That's what that means, and with what they had at their disposition at that time, that is what they felt he presented with, because he at one

point in time did report hearing voices or somebody said he has psychosis or schizophrenia. What they may -- and, again, I don't think they had that information, because subsequently one learned that this presentation was malingered, fake, and, therefore, that diagnosis was ultimately dismissed.

THE COURT: I see. Thank you. Mr. Gray?

MR. GRAY: Thank you, Your Honor.

BY MR. GRAY:

Q So to ask the question in as simple a manner as possible to get a yes or a no answer -- and if you don't understand the question, just say I don't understand the question.

A Sure.

Q Did you make a determination as to the information provided to you by Mr. King as to whether or not you believed his information or did not believe his information?

A Well, -- tell you this. I already talked about this earlier. It would be foolish for me to say I believe what he told me and I disregard what he told others. How can I believe him even if he talks to me because he, in his eyes, knows I'm retained by his attorney, so he may have the perception that I'm going to be just a hired gun who's going to come up with

whatever he wants to help him with the case? That's not the approach I took. I listened to him, heard what he had to say, but I didn't take it at face value and said because he's now telling me a given story or gives me a narrative, I just run with that.

I look -- I incorporate that information into my database, and the database is 3,000 plus pages and consider that information, but it certainly didn't have any weight on my ultimately conclusions with regard to the diagnosis I gave him and with regard to the issue of the statutory definition of a sexually dangerous person.

Q So that would be a yes, you had to weigh the credibility of the information provided to you by Mr. King?

A -- tell you this. I'm not weighing the credibility. I mean, when I went into this assessment, I already knew that he has been described as being manipulative, deceitful, a liar, a pathological liar, so I would have to be ingenuous going into that and say well, today he is going to tell me the truth, I'm the first person in the world he's going to tell the truth about his life. That would be -- I mean, some people may do it.

I didn't go into the interview with that approach because I knew whatever he's going to tell me,

I have to take it at face value. I can't take it at face value. I have to put it into context, and the context is that of a chronic liar.

Q So let's take a look at your report and take a look at some comments that he made to you. So if you would turn to Exhibit One and go to the second page of your report, in your report at the top of the page, you had interviewed him for about four hours and 30 minutes, correct?

A About, yes.

Q And in the personal history section, you write that you used direct quotes because you wanted to make sure you had accuracy, isn't that right?

A Actually, the accuracy doesn't mean that -- accuracy doesn't mean that it's reliable or credible. It means that I didn't want to misquote what Mr. King told me, so it's an accurate reporting to me at the time of the interview. That's all -- what I mean -- given the verbatim quotes I take out of the records is I didn't want to misconstrue something or misread information and present it in a way that it is not accurate and that it was observed, perceived by whoever wrote it -- certainly don't -- 20 years ago, that's why I used the quotes, and that is what I mean by -- doesn't mean reliability or credibility.

Q I understand and I appreciate your answer, but I'll ask you questions for clarification, if necessary. If you can do me the favor of just answering the question, this will go a lot quicker.
A I'll do my best.
Q Thank you. Now, on page three of your report, there's an indented portion that begins with the personal account of his life.
A Yes.
Q That indented portion, that's a portion that you took out of another report for accuracy, correct?
A No, it's not. I took it -- I mean, it's indented because -- for accuracy because I tried not to misquote, yes.
Q And in that indention, the second line says in describing his childhood experiences, he relayed example after example of how he felt humiliated and hurt by other children who intentionally made fun of his disability. Do you see that line?
A That is what this reads, yes.
Q Now, with regard to that line, looking at it in context, is that a report from Mr. King?
A If I just read what I have, I would have to look at the context of this document, but the way it's written, it would suggest that it's his description of

his experiences at that time.
Q And was this one of the things that you have to evaluate when coming to an evaluation or at least a determination of Mr. King's conditions?
A No, absolutely not. I mean, the issue is not because I say well, I don't rely on the things he's telling me or Doctor Zinik or vice versa. With Mr. King, the issue goes back not to just to the last two years. It goes back to his entire life. So whatever he may have said to somebody down -- ten years, 20, 30 years ago, that -- again, I don't think I can give it credence, because he was described as being a chronic liar, manipulator early on in his life.
Keep in mind, we don't suddenly become a manipulator or a chronic liar. It's not like I'm waking up and I suddenly become this liar. There's a past to lying, and given that, whatever he may have said to somebody down the road good or bad, favorable or not favorable, you can't give any weight.
Q So you chose not to give that any weight?
A Well, I chose to consider it. As you see, I wrote it down, and what I tried to do -- maybe that's -- explain this. I tried to provide The Court with some examples of what I see these records say, because otherwise, I -- I mean, to be more complete, I would

have to write probably a 200 page document, 300 page document describing all the various aspects, behaviors and presentations he had over the course of the years. This is -- if you want to -- as far as I could do a snapshot of what I thought would get my point across as to how I see his case in terms of his reporting.

Q So in that next line where it says education and work history, that next paragraph, do you see that?

A Yes.

Q The line -- it says he reportedly got along with his peers and did not pose a disciplinary problem, noting I didn't have a lot of fights with kids. Was that what he told you?

A That's what he told me, yes.

Q Did you believe him when he told you this?

A How can I? I mean, if -- then go a couple pages further --

Q Doctor, I just want to ask did you believe him about that statement?

A So my answer would be without any further elaboration, how can I do that? Do you want to allow me to elaborate?

Q I'll allow you to elaborate, but I just want to make sure I get the answer to the question. So did you believe that? Yes or no?

A The answer would be negative, that I did not believe him because I would and did consider other things that I read about him, that he got himself in fights at that time period in his life. So whatever he told me -- that he was a good kid in school, no problems was contradicted by other records that described him as being a fighter.

Q And then two lines down when he told you that he dropped out midway through the 11th grade because he was trouble -- because "I was in trouble with the law", did you believe him there?

A He made a statement that he dropped out in school. I think there was some other information in the records, and most likely by memory that did support it. I don't know if it was verified independently. So the answer would be did I -- and did I have the opportunity to verify independently? I don't think I had. Do I believe him? In a certain sense, I think certain sections of what he said is credible because I do know he got his GED at a later time and I do understand you can't get a GED if you completed high school regularly, so that may be accurate.

The issue of being bullied in grade school -- who knows if that's true or not? That's Bates stamped so that -- I don't know if it was his report,

but the issue of the GED is -- I would say that's credible because I understand he got his GED subsequently. Therefore, he dropped out. That's possible. I mean, it's not possible. It's more likely than not that he did --

Q Okay, Doctor Saleh. Once again, the line I was reading you was the dropping out midway through 11th grade "because I was in trouble with the law". That line -- and I'll allow you to elaborate, but I just want you to answer the question first.

A Yeah.

Q Did you believe that line?

A I'm not sure at this point if I believed him or not, because I know that he is not believable, so I don't remember if I believed it. I would have to go back and see if -- when he was -- when he dropped out of -- midway through the 11th grade if it was consistent in terms of chronology with the time when he got in trouble with the law. I don't remember that offhand.

Q So would it be fair to say that when it came to determining whether or not something he told you was believable or not, you'd check it out with other sources to determine whether or not that was believable or not?

A Depends. Again, it depends on what the report is. I mean, if it's a report of having a fantasy, there

is no instrument I can use to determine if that fantasy is true or not, but if it's something that I can verify independently through, for example, school records -- could certainly try to corroborate some self-reports.

Q And a little further down in that page, it says Mr. King is reportedly a "qualified tree surgeon".

A Yeah.

Q Did you believe him with that statement?

A Well, I, first of all, didn't understand at the beginning what a qualified tree surgeon is, and that is something he said to somebody else at one point in time, and so I think what I have here -- and the quotes makes reference to the Bates stamp page 231. I don't think -- and I don't remember though -- I -- that he said this to me. I do know in various other records there was made reference -- the reference was made to the profession he had which is landscaping and also working around trees and trimming trees. That's at least my understanding of what he may have done.

Q And on the next page under medical history, that first line says Mr. King's medical history is significant for caves (sic.) foot. Is that a self-report to you?

A No, because I don't think he would use that language. That's from the medical history section of the

records I got.
Q Do you believe that portion of the medical history of the records?
A Well, caves foot, I don't need to believe somebody or don't believe. It's not something I can say I have. You have it or you don't have it, and I think if I look at somebody's feet, I can say if they have caves foot or not.
Q Now, in that same paragraph as we go towards the bottom, it says he also suffered a closed head injury at 15 years old "getting into a fight with some fellows and they hit me with a piece of wood". Is that a report that he made to you?
A That's a report he made to me.
Q Did you believe him when he told you that?
A Who knows? I don't know. I don't know if that's true or not true. Again, I'll tell you this. The point with Mr. King is he has told lies for 35 years, and with all due respect to him, I have to say -- but he has not been honest. I mean, he has been deceitful. It's possible that it happened. It's possible that it didn't happen. I didn't see any records that would support that he was in an induced coma, and so I don't know. I could not verify this, as far as I recall.
Q And outside the comment about the coma, because

that's not on that line, it says he also suffered a closed head injury at 15 years old "getting into a fight with some fellows and they hit me with a piece of wood". If somebody were hit in the head with a piece of wood, would that be something that could be verified by looking at medical records?

A Sure. Let me actually take this back. It depends on the injury to the skull. I mean, if I have a caved in injury to the skull and with subsequent brain damage, I could verify this, but if I got hit with a piece of wood, I may have just a bump, but that would go away after a couple hours.

Q Now, you mentioned earlier about a coma. Did you get that information from the record?

A That's actually I think what he told me, that he was in an induced coma.

Q And did you do anything to verify whether or not he was in an induced coma or in a coma?

A Well, I reviewed whatever I had at my disposition. I didn't go and ask for additional medical records pertaining to 1975 or so, so I didn't do anything beyond what I had at my disposition.

Q Were there any other medical records or records within the thousands of pages that you received that made reference to a coma?

A I don't remember that.
Q And was the coma referenced in the medical reports and the psychiatric notes that were taken at Phipps Hospital?
A I don't remember. I would have to look at it. It may have -- may not have. I don't remember.
Q Would it help refresh your memory if we were to show that to you?
A Sure, absolutely, if you have it.
Q Doctor, in front of you there's another binder that has Government exhibits within it.
A This is the white --
Q Yes. If you would, turn to Exhibit Number Nine, please, Doctor. Are you there?
A Yes.
Q Okay. If you would please turn to the pages that begins on -- at the bottom, it's Bates stamped 1501.
A Yeah.
Q Okay. And if you would -- sorry. Let me get you to the right page.
MR. GRAY: I'm sorry, Your Honor. The computer is taking a little bit of time. I'll move forward and I'll come back to this issue.
BY MR. GRAY:
Q Doctor Saleh, if you would take a look at that

same paragraph where it says that he had surgical removal of some supramammary nipples on the left thorax and right abdomen, --

A Yes.

Q -- do you see that?

A Yes.

Q Did you believe that statement from the record?

A Well, it was documented in the records. I didn't do a physical examination on him to determine whether or not that's true.

THE COURT: Doctor Saleh, if you could, to the extent you are able, if he asks you a yes or no question, if you could, answer yes or no. You certainly are entitled to explain your answer. That would be helpful.

THE WITNESS: Sure, yeah.

BY MR. GRAY:

Q And, Doctor Saleh, if you would go down to where it says substance abuse history, that paragraph, are you there on your report?

A Yes.

Q That second line begins with he reportedly began drinking alcohol at the age of 13 years old.

A Yes. I see it.

Q Was that a report to you?

A That's what he told me, yes.
Q And did you believe him when he told you that?
A If I believed him -- upon verification, yes.
Q And then the next paragraph, the second sentence begins with Mr. King continued to abuse drugs and alcohol in the prison system, having last used heroin in May of 2009. That last portion, last used heroism -- heroin in May of 2009, did he tell you that?
A No. That's Bates stamped reported. I think it may be a urine toxicology screen.
Q Did you ask him whether or not he had last used heroin in May of 2009?
A I don't remember if I did.
Q Did you believe that statement where it says that he last used heroin in 2009?
A Well, it was verified by a urine toxicology screen, so -- somebody hampered with his urine tox screen or his urine or it was his urine, so I would say I believe the urine toxicology screen was not hampered with or there was no evidence to suggest that it was another person's urine.
Q And in that next paragraph where it says relationship and sexual history, do you see that subheading?
A Yes.

Q The line that begins in that same paragraph Mr. King is a bisexual man, did he report that to you?
A I think that was his report, yes, when I saw it.
Q When he told you that, did you believe him?
A When he told me, I was not sure to believe him or not to believe him.
Q Do you believe him now?
A Well, it depends, and if I could elaborate -- because I do know that he has engaged in homosexual activities with other inmates.
Q How do you know that?
A That's per the record.
Q And these records -- you have that cited on there as Bates stamp page 2454?
A No. That is what he described himself to be at one point in time. I think there were documents in the record that talked specifically about him having had sexual activity with other inmates.
Q But, Doctor, wasn't that also a self-report?
A I'm not sure. I would have to look at the records and see if that was based on a self-report, his self-report or that of another inmate. I don't remember. I would have to look at it.
Q Do you have those records in front of you?
A I don't. I have just my report with me today.

Q So in your mind, it would make a difference if it were reported just by Mr. King, but it would take on a different weight if it were reported by another inmate?

A Not necessarily, because it really depends again what you try to accomplish and the scope of that question, the context in which the question is asked and what that question or the answer he gives or doesn't gives means. So if you take it a step further, the question is would he have an ulterior motive to report that he is bisexual, homosexual, heterosexual or asexual? I mean, that's the way I would look at this, and as far as I can say at least, he doesn't have a ulterior motive to claim to be bisexual or homosexual and, therefore, if he stated to be bisexual or if it was reported that he had engaged in sexual activity with another inmate, in the absence of a ulterior motive or he's just making it up, which is -- that's certainly possible if it's just based on his self-report or it's something that is true, but there's no reason for me to suggest or for somebody else to suggest that that report is fabricated.

Q So in that last line on that paragraph on page four of your report where it says when I asked Mr. King about his sexual orientation, he acknowledged a history

of homosexual behavior, you believed him?
A Not -- again, at the time I asked him, keep in mind that I hadn't read the entire records at the time I went and interviewed him. I just solicited information, and then when I went home, I started going through the entire records and subsequently getting other sets of records. So I took down the information, what he told me, and then I went and tried to verify, cross-reference whatever he told me to see if there is something to that report or not.
Q Okay. So when you cross-referenced to determine whether or not there was something to this report or not, did you believe it?
A -- he is saying homosexual behavior. Homosexual behavior doesn't mean homosexual orientation, so I may engage in homosexual behavior without being homosexual. And as far as I recall, the records -- he has engaged in homosexual behavior, so that may be, indeed, an accurate self-report.
Q So you believe it when he said that he has a history of homosexual behavior?
A That he acknowledged a history of homosexual behavior, I think that's consistent with what the records said about him in the DOC system, that he has engaged in homosexual behavior.

Q Including his self-report?
A Including the self-report to me on that given day.
Q And the self-reports within the records?
A No, not necessarily, because at -- time he said he was heterosexual. Then he said he's homosexual, and then he says he's bisexual. I'm making reference just to the homosexual behavior.
Q I am, too, Doctor.
A I see. Okay. Sorry.
Q So with regard to the homosexual behavior, you found that that is consistent even though he made statements within the record -- self-reported homosexual behavior?
A Again, I would have to look through the records, but as far as I recall, there was records and record entries describing or talking about him having engaged in homosexual behavior.
Q There is on the next page the paragraph right after the indentation -- I'm sorry. The paragraph with the indentation, that line begins with since age 13, his sexual fantasies have mainly concerned his exposing himself. He's had no homosexual ideas or experiences. He first had intercourse at age 13 when a girl asked him to have sex with her. When he does have intercourse, he

fantasizes about exposing himself or about tying up women and raping them. That statement, you have that indented in your report.

A Yeah.

Q What's the significance of you having that statement within your report?

A Well, because I didn't want to omit information that one needs to look into in a case like this one, given that there was the notion of paraphilia NOS -- the nonconsent business, but given that, I didn't want to just select certain information out to say well, there's nothing in the record. So because there is this statement about raping, I thought it's important that I have it in there, and that's the reason why I put it in there.

Q So it's a fact that as late as -- as early as 1976, we have him self-reporting fantasies about exposing himself and fantasies about tying women up and fantasies about raping them?

A Not the way you said it, because I don't think it's a fact. It's a self-report of a chronic liar who already -- was described to be a liar, so I'll tell you this. The point is it's a record entry that I have in front of me, as I have many record entries about his other self-reports, and that's one of many other record

entries that go back to his fantasies. But, again, if I talk about the fantasies of the person in front of me and this same person is described by the Phipps Clinic as extremely manipulative and lying, that's the context. So within that context, that is what he said.

Q Looking at the context, do you believe this self-report from 1976? Is it accurate?

A You asked me to do something that is impossible for me to do and -- for me or anybody else to go back in time and say that report is accurate. What I can tell you is -- because it's really impossible. How could I determine if that's accurate or not?

Q I can help you by asking the question differently. Do you consider that to be an accurate statement?

A The answer is that I don't know if it's accurate or isn't accurate. The likelihood -- that it's not accurate is because he at that same time was said to be a liar and manipulator, and so if you take that -- and, again, that is something that I can't, again, dismiss, because that's a theme that has been going on consistently over the course of the last 40 years of his life, lying, being -- manipulator and so forth. That's the context, so within that context, he may have reported something for some ulterior motive at that

time, which could be abating punishment and being put into a hospital rather than a juvenile delinquency type of -- setting.

Q With regard to a paraphilia diagnosis, would you consider this as part of that diagnosis?

A Absolutely. I mean, how could I do this? I mean, if you use that as the diagnosis, again, what you would then do is -- and I certainly understand your position, but what you would do is if you were to do that is you have -- and would have -- only way you could do it is to say I have to select everything else out and let me just look at a given theme, given statements he made over the course of the last 40 years, and that's not the way at least I practice medicine or diagnose people.

I don't select information out. Look at the entire database, the totality of the data, you put it into the context, understand who this person is in terms of his reporting patterns, and then based on that, you may or may not be able to draw conclusions with regard to a diagnosis.

With this case and with this statement, I mean, keep in mind the time we talk about. He is now arrested, got himself in trouble. I know the Phipps Clinic. I worked on the same unit where Alessi worked and Dietz worked. I know what the goal and objective is in

treating people, help people and so forth. So if I'm the manipulator, I have a ulterior motive so I can avoid going to a DYS facility and I end up on the clinic and just report that I feel bad and have these bad thoughts so I can be kept on that facility. I mean, that's the context, so given that, I don't think that I can just run with this and say let's make this the foundation of my diagnosis of whatever paraphilia you want to call it.

Q Now, you said this -- this is from the Phipps Clinic, correct?

A As far as I know, that's right, from Johns Hopkins Hospital at that time.

Q And if you take a look at Exhibit Number Six in the white binder --

THE COURT: Let me just note for the record, the indented paragraph we've been talking about is in Respondent's Exhibit Number One on page five. It's the first indented paragraph on that page.

MR. GRAY: Thank you, Your Honor.

BY MR. GRAY:

Q Are you there?

A Yeah.

Q Thank you, sir. And, sir, if you were to go to page 1500 --

A I -- say Exhibit Six?

Q Exhibit Six. I'm sorry. Exhibit Nine.
A Yes.
Q Page 1500.
A Yes.
Q Are you there?
A Yes.
Q Is this page 1500 that you referenced on the indented paragraph on page five of your report for the Respondent?
A I have to look at it. Yes, it's actually right there. Well, let me see. I don't know. I would have to -- let's see. Yes, that's it. That's actually the third paragraph.
Q Now, you're looking at that paragraph and saying that you can't look back at history to determine whether or not it's valid, correct?
A I'm not sure if I follow the question. You say -- I look at this paragraph and I say I can't --
Q Well, let me ask you this.
A Yes, please.
Q This paragraph that's on the indented paragraph of page five of Respondent's Exhibit One, since age 13, his sexual fantasies have mainly concerned his exposing himself, has had no homosexual ideas or experiences. He first had intercourse at age 13 when a girl asked him to

have sex with her. When he does have intercourse, he fantasizes about exposing himself or tying women up and raping them. I asked you earlier whether or not you would consider that as part of a diagnosis for paraphilia and you said of course not.

A -- if I said it the way you said it, because I said -- I really don't think I said it the way you said it. I said when I asked to look at it into the context you are in, you have to understand who the reporter is, what the characteristics are of the reporter and how the reporter has presented over the course of the ensuing years, so --

Q So in this case, the reporter is Mr. King, correct?

A Yes.

Q And the context of the reporter that we're considering is he's a chronic liar, isn't that right?

A That's the way he was described, yes.

Q And he was described as a chronic liar as you testified earlier by those at the Phipps Clinic, correct?

A I'm not sure if it was. What I said was at the Phipps Clinic, I know that he was described as being a chronic liar, extreme manipulator, something along those lines, but, yeah, I mean, I think it actually -- that it

was the Phipps Clinic. Let me just double-check. It was a note -- I'm not sure if it's from this one, but -- let's see. I think so. I mean, as far as I recall, it may be a Phipps Clinic related -- I mean -- be from the Phipps Clinic. I don't remember.

Q So at the time of providing this information, to the best of your knowledge, he was known to be a chronic liar?

A He was known to be deceitful and dishonest, yes.

Q And this note was done by Paul Elliott Dietz. Do you know a Doctor Paul Elliott Dietz?

A Let's see -- it's actually Park Dietz, not Paul.

Q Okay. I'm sorry. Park Elliott Dietz?

A Yeah.

Q And Doctor Dietz is a Nationally renown psychiatrist, correct?

A He's a Nationally known psychiatrist. Renown -- up to others to determine.

Q And did Doctor Dietz come up with the diagnosis for Doctor King at that time?

A Actually, the way this works at Johns Hopkins is -- and I have to tell you I didn't look at Doctor Dietz's CV, but as far as I know, if you're a resident -- I mean, you're a resident physician, you have a supervising physician, and if I'm not mistaken,

Doctor Alessi was the attending physician and Doctor Dietz was the resident physician. Actually, yes, I'm actually correct. So the attending is Doctor Alessi and Dietz is the resident physician most likely.

So your question, did he, Doctor Dietz come up with the diagnosis, I don't think I could determine that.

Q But Doctor Alessi did come up with a diagnosis, one of which being exhibitionism?

A Yeah, sure, yeah.

Q And that diagnosis of exhibitionism was based in part on the information that you have at the top of that indented paragraph on page five of your report?

A Again, you ask me to put myself in the shoes of the doctor at the time. What I would add to that is that if I'm not mistaken, Mr. King at that time prior to the admission to Hopkins had exposed himself to children, so there was actually factual evidence of exposing, if I'm not mistaken, and then he went on and then reported exposing related fantasies.

Q So the exposure fantasies would be disregarded in a diagnosis?

A I mean, again, keep in mind, the thing is, if you have a patient coming to your clinic and he's a 15 year old adolescent who was exposing himself and you

don't have the luxury to know what this person is going to do 30 years down the road, you don't have the luxury to know what his psychosexual development is going to be, but what you have -- the evidence at that time is that this is a troubled child, he exposed himself to children, he's reporting those fantasies. That's the report you have from the 15 year old adolescent who presents with conduct disorder or conduct disorder related behaviors.

Q Not to interrupt you, Doctor, but he was 17 at the time he was at the Phipps Clinic.

A Oh, 17. I mean, he is -- adolescent at that time, yes.

Q So we have a 17 year old fooling a Board certified doctor and a person that later became a world renown, Nationally renown psychiatrist?

A Absolutely. I mean, again -- tell you this. The issue of psychiatry -- the best example is the discussion here about the paraphilia NOS, nonconsent. It's not like I can go and use -- x-ray and determine if I have exhibitionism or not exhibitionism. It's based on many times the reporting of the individual. And can I be fooled by a patient and a chronic liar who has the skills to lie and mislead me? Absolutely you can, and it can be Doctor Alessi, it can be Doctor Dietz, it can be

me, it can be somebody else. It's absolutely possible that you can be fooled.

It would be -- I don't think that your credentials would make you more apt to not -- would make you more apt not to be fooled. What I think is critical is when it comes to the -- not necessarily the reputation, but the skills of the doctor is to put things into context and understand the case and -- rather than just going with the information you have in front of you.

And, now, again, here we talk about a 17 year old child who presents with exposing behaviors in this report, so I think it's reasonable at that time to make that diagnosis, but for me to go back 40 years later and still say that that's a valid diagnosis in the absence of a -- data and a reporter who is a chronic liar, that would be not appropriate.

Q But it's reasonable in the context?

A I mean, the context being --

Q Just using your words.

A Yeah, sure. I mean -- the context being in '76, 1976, December, 1976 and you get this young man to the hospital, to the unit, you have what they used to -- I think -- behaviors unit. To have this patient there, he is -- he got himself in trouble for exposing behaviors.

He's telling you that he has this trouble. At that time in '76, that would be a reasonable diagnosis to give him.

Q So with regard to a diagnosis that you gave to Doctor King -- to Mr. King, you looked at his statements and the other information in the records in context, did an independent evaluation of the information, looked at things that could corroborate or, for lack of a better word, say that that couldn't have happened in order to help form your opinion?

A I apologize. I may have missed the question. So you're saying that I did what? I apologize.

Q Would it be fair to say that what you did is you reviewed the record, took a look at Mr. King in the context of his chronic lying, took a look at the information within the record, his reports, reports of others and all the other information and then used that in order to make a determination as to what's the most appropriate diagnosis for Mr. King. Would that be fair to say?

A I think so, because, again, just to make sure that we are on the same page, what I did is I did review the records that are available to me, and the records include his reports, and I established hopefully previously that he is not a reliable reporter, he has

been described as being manipulative, deceitful, chronic liar, pathological liar, all those type of things, was given a diagnosis among many other things over his lifetime of exhibitionism, and then I looked at the totality of the information in front of me and then drew conclusions with regard to scientifically valid clinical diagnosis that would be, if I understood you correctly, accurate, but that's what I did.

Q And you testified earlier that you don't accept some data. You evaluate all the data. You don't just take some data and just toss out other data.

A The issue of tossing them out or not, it's not -- and, again, I may not have been clear on this. The issue is I look at everything I have in front of me. I even look at this paraphilia NOS, nonconsent condition Doctor Zinik diagnosed Mr. King with to see if there's evidence in support of that information, condition or whatever that may be, and so I don't toss things out. I rule out diagnoses and conditions.

And the example to give you is I can come in with a fever to a primary care doctor and I'm not just going to be biased because I sell Penicillin and say you have a bacterial infection and take this antibiotic. I look at the symptom of the fever, try to understand what context that occurs, that -- numerous conditions that

can cause fever, including making it up or just putting your head under the hot water if you have a very -- temperature, and then based on that analysis, I may be able to draw conclusions with regard to diagnoses or not, but there is analysis going into that symptom the patient presents with, which is the fever, which includes also is this an accurate report or not.

Q Now, paraphilia NOS is in the DSM-IV-T-R?

A Yes.

Q And the DSM-IV-T-R reads that this category is included for coding paraphilias that do not meet the criteria for any specific categories. Examples include, but are not limited to, telephone scatologia, obscene phone calls, necrophilia, corpses, partialism, exclusive focus on part of the body, zoophilia, animals, coprophilia, feces, klismaphilia, enemas, and urophilia, urine. You're familiar with the DSM?

A Sure.

Q And it says that examples include but are not limited to that listing of, I guess, identifiers I read to you, correct?

A Yes.

Q For instance, you testified earlier that that was touchism? (phonetic)

A Toucherism.

Q And is that in the DSM?
A No, it's not.
Q But you said that you can find that. Why is that?
A It's a phenomenon and a description of a paraphilic disorder that has been used. John Money would be one who has described toucherism as a phenomenon, but it's not in the DSM, didn't make it into the DSM because there is no scientific foundation, empirical evidence today to support that specific condition. You have frotteurism for which you have empirical evidence. The thing is if you look at those conditions you're talking about, it's empirical evidence.

The paraphilia NOS diagnosis or the NOS, nonconsent, what it also said is that the NOS -- consent category should not be used as a proxy for something that doesn't exist, so I couldn't just now say because there is this -- and this is what people do, unfortunately, that -- they say there is this NOS, nonconsent and I get that -- exactly that reading from the attorneys or other people that say look, it says e.g., not i.e., including but not limited to, therefore, why can't you put in some other NOS, consider this as NOS defined paraphilic disorder. That's where you go back and look at the empirical evidence behind

that condition, and if there is no such evidence, it wouldn't make it even in the NOS category.

And, again, I said the issue is it should not be used as a proxy for rape or criminal behavior, and that is what has happened. And if you look at actually what I found yesterday evening from the Psychiatric Times, the California DMH takes a stand against the paraphilia NOS, nonconsent issue, and you should read this, because that's very enlightening. It talks about the issue of the misuse of the paraphilia NOS, nonconsent diagnosis, that it's not exist -- that's hot out of the press, October 10, 2011, and that talks about what I'm talking about, that this NOS, nonconsent -- no evidence, no diagnosis and doesn't make it into the paraphilia NOS, nonconsent.

Necrophilia -- there is a condition described as necrophilia in the literature. There is evidence. There are people who get excited, aroused by corpses, and it's not a common diagnosis, so it's not listed among the other diagnosis you have in the DSM, the paraphilia exhibitionism. It's because of that it's put in the NOS category, but the -- again, the point is I can't go and say I'm going to make something up to make my case. That's not the way medicine works. That's not the way science works, and that is what has happened

here.
Q But, Doctor Dietz, (sic.) paraphilia NOS is made up?
A I'm not Doctor Dietz. I'm Doctor Saleh.
Q Doctor Saleh. So paraphilia NOS is made up?
A No. You didn't get my point. I'm saying NOS is not made up. As you very well pointed out, it's in the DSM. It's the last paragraph pertaining to the paraphilias. It's a category used in the DSM, and there is e.g., and you listed the five paraphilias they listed there.
Q Actually, they noted them as categories, not as paraphilias.
A I don't know at this point what you're pointing to.
Q Oh. I was reading. It says these specific categories included scatologia, partialism, zoophilia, klismaphilia, urophilia. It didn't call those paraphilias. It called them categories.
A It's paraphilias within the category of paraphilia NOS. I mean, that's the way I would understand what you're saying. The point is -- I mean, my point to you is I'm not saying that there is no such condition like paraphilia NOS. I'm not saying that. What I'm saying to you is that there's no such condition

as a paraphilia NOS, nonconsent. That doesn't exist.

So if you want me to make it up because you want me to make a case for you, there are people who do it. I'm not one of them. And the APA rejected their approach. The National Association for Social Workers rejected the approach. There are some people who do it for whatever reason. I don't know what their reason is, their motivation is to make things up on the fly to use it to make their case to say somebody suffers from a condition.

It's like saying I'm selling Penicillin, you have a fever, you have pneumonia. That's not the way I would practice medicine. Some people do it though, and they get rich by doing that. That's not the way I think one should practice medicine or apply the science to a forensic case.

Also, keep in mind, if I have NOS, what does this really mean? It means not otherwise specified. When I use NOS, that tells me if I read it that I really don't know what this person has. How can I then go and say it's to a reasonable degree of medical certainty or professional certainty that if I already by using that category say that I don't know what that is because it's not specific enough to the presentation in front of me?

So you have double trouble here, that, one, I

use the condition that is not specific enough. Then you have at -- the nonexisting issue about the paraphilia NOS, nonconsent, and then I go and even try to pretend to say to a reasonable degree of medical certainty. How can I be presenting information to a reasonable degree of medical certainty if I don't know what specifically this person suffers from? And by using the NOS diagnosis, that's exactly what you do.

Think about anxiety disorder not otherwise specified. What does this mean? It means that I don't know if this man suffers from generalized anxiety disorder, obsessive-compulsive disorder, separation anxiety disorder, specific phobia, social phobia or PTSD, post-traumatic stress disorder. So there's specific diagnosis -- by using the NOS, that's what this means, and I'm misleading in my judgment -- a trier of fact by saying look, my opinion is to a reasonable degree of medical certainty that this man is suffering from this condition where I don't know even what the condition is. How can you do this? And that's where the problem is, and add to it then something that doesn't exist, there's no science behind it, you end up creating something that doesn't exist.

And, again, people are entitled to be unethical in the execution of the profession. I'm not one of them,

and I don't think it's appropriate, and, therefore, I don't think I'm coming up or will make -- diagnosis based on inexistent data.

Q And so you're saying that it's that identifier of nonconsent that you're saying there's no -- there's an absence of data?

A That's not the issue --

Q Okay. Well, let me ask it this way. Mr. King was diagnosed with paraphilia NOS. That's a diagnosis under the DSM, correct?

A That's a diagnosis under the --

Q And that was a diagnosis that he was given, correct?

A No. Again, what you're now doing is you're actually making it worse. You're -- it's like saying that I have a condition --

Q Touchism?

A No, no, it's not that. What you're doing is you are saying let me not talk about some part of the diagnosis but the other part that makes my case. You can't now say well, I'm going to just focus on the paraphilia NOS and let's forget the nonconsent that was given to him, because the purpose -- and I don't know Doctor Zinik, but there was a purpose why he used the nonconsent qualifier or description. So I can't now have

it both ways and say well, let me just focus on the NOS because I can make my case and let's disregard what has been dismissed and refuted by all the organizations Nationally and internationally as a inexisting diagnosis.

So what we have to focus on is paraphilia NOS, nonconsent. That's what the diagnosis is that he was given by these three state examiners, and, as I told you, there is no such diagnosis. It's made up, and, again, some people make things up while they go, and our profession would prohibit such behavior and would prohibit such conduct.

Q So it's your testimony that Doctor Zinik's diagnosis was not paraphilia NOS but was paraphilia NOS, nonconsent?

A No. Actually, he used even some other qualifiers. He described a different --

Q Wait, wait, wait. You said qualifiers. What's the difference between a qualifier and diagnosis, please?

A Yeah. If you allow me, I -- explain this. So he started -- and I -- best would be if I can look at this report, because I didn't memorize something that I -- that he wrote, but my --

Q It's in the exhibit book.

A What number?
Q It should be Exhibit Number Five.
A Okay. So what we have here is -- okay. So what he said is --
Q And there was an updated one in 2000 -- the most recent one is on Exhibit Number 57.
A Right. And I think his diagnosis didn't differ, as far as I know, but let me just tell you what he said. He says the diagnosis under Axis One is paraphilia NOS, forced sex with nonconsenting female, also known as paraphilic coercive disorder. So if I take this and if you want me to use a nonclinical term for what this is, that's bogus. There is no such thing as paraphilia NOS, forced sex with nonconsenting females, also known as paraphilic coercive disorder.

Paraphilic coercive disorder was first introduced used in the early '80s, refuted by the APA in I believe 1984, APA meaning American Psychological Association -- refuted by the American Academy of Psychiatry and the Law, by the National Institute for the National Social Workers and Criminal Justice System. Paraphilic coercive disorder -- then Darwin came onboard and said now, let's not call it paraphilic coercive disorder, let's call it paraphilia NOS, nonconsent.

So what Doctor Zinik did is he's now combining

two things that -- again, I don't know how he did it. You want to ask him how he came up with this idea to do it the way he did, but he's now mixing two things together, one, the paraphilic coercive disorder and the non -- NOS, and then he adds this forced sex with nonconsenting females. As I told you, there's no empirical evidence in the literature that would support this condition.

And take one step further and say I'm the treating doctor and this -- and I'm just a prescriber and this patient comes in with this diagnosis and I'm asked -- prescribe -- medications to this patient because he suffers from paraphilia NOS, forced sex with nonconsenting females, also known as paraphilic coercive disorder. If I were to do it and this person were to experience an anaphylactic reaction to the medication I'm prescribing, I can assure you I would be sued for malpractice, because in order to prescribe, I have to have the foundation in terms of diagnosis. If I'm operating on a flawed diagnosis that doesn't exist and I throw a medication at this patient and he gets an anaphylactic reaction, likely I will be sued for malpractice and most likely I will lose because my diagnosis doesn't exist. So that's what the problem here is.

I mean, if you have somebody who -- choose to do this, Doctor Zinik and the other two state experts, but that's not in accordance with the signs behind paraphilias and the literature pertaining to sexual disorders.

Q So it's your testimony that he did not diagnose paraphilia NOS?

A Let me just see if I understand your question now.

THE COURT: I think that question has been asked and answered already.

MR. GRAY: Thank you, Your Honor.

THE COURT: I think we've plowed this ground that we've been talking about quite well. Why don't we take our lunch break and reconvene at 1:05?

(Whereupon off the record.)

THE COURT: Doctor Saleh, let me remind you, sir, that you do remain under oath.

THE WITNESS: Yes, sir.

THE COURT: Very good. Mr. Gray?

MR. GRAY: Thank you, Your Honor. Your Honor, we have one housekeeping matter that we'd like to bring to The Court's attention, along with a motion that we would like to make along with that. We were notified during -- just prior to the lunch break by the Marshals

Service that there may have been an act that would be relevant in terms of the opinions of the experts as well as probably the bearing on The Court with regard to conduct that may have taken place by Mr. King while he was in the custody of the Wake County Sheriff's Department.

We're trying to ascertain the details behind that, and from our understanding, the sheriff -- the deputy sheriff that was involved in the incident is not -- they're in Fayetteville some place roaming around the county, so we're trying to get in touch with that person so that we can get a copy of the report in order to ascertain what to do.

With that, we would be moving The Court to maintain and keep the court open until we get an opportunity to provide that information for consideration, at least for Respondent's Counsel that -- so that they have an opportunity to receive this information as well, and then we can provide it to The Court.

THE COURT: What was the date of this alleged incident?

MR. GRAY: Last night, Your Honor, or sometime yesterday.

THE COURT: I see. Mr. Bell, do you wish to be

heard on that?

MR. BELL: Well, Your Honor, I found out about this alleged event about five minutes ago, don't really know the nature of it. I don't know how it will affect the hearing or whether it will affect the hearing in any way.

I know that I've got an expert here who's testifying. The information may or may not be relevant to his testimony. I don't know when we're going to get the testimony or the information. I would hate to keep him here overnight to have to testify about it tomorrow as to whether it's relevant to his opinion or not, so maybe by the end of the day, we'll know more and The Court can make that decision, but I'm kind of -- at this point, I don't know enough about it to really be able to comment.

THE COURT: That's fine. Mr. Gray, is the Government trying to get this deputy here today?

MR. GRAY: Yes, Your Honor. We're trying to get the deputy. We're also trying to locate them in terms of getting their report, because from what our understanding is, the report has not been generated yet. It's in the process of being generated by the Wake County Sheriff's Department.

As an alternative, we understand that Doctor

Saleh has a busy schedule. What we would recommend is we can provide this information in documentary form to The Court for its consideration. Of course, we'd provide it to Respondent's Counsel initially, and if The Court felt it was necessary to hear the testimony, then we can look for that, but we'd offer alternative forms of testimony and certainly would provide it to Doctor Saleh and the other experts in handwritten forms so that they can use that to inform their decision.

THE COURT: Okay.

MR. BELL: Just --

THE COURT: Yes, sir?

MR. BELL: -- for clarification, Your Honor, if there's a report that involves conduct that my client allegedly engaged in, then I would object vehemently to The Court receiving a report in lieu of live testimony with the possibility that I can cross-examine the individual who generated the report, who saw the alleged conduct and so forth. So I would not agree, nor would I -- I would object vehemently to that.

THE COURT: Okay. Well, my suggestion for the time being is let's proceed with Doctor Saleh. We don't have a report or a witness to be concerned with at the moment. Let's see where we are at the end of the day once we've completed the other testimony.

MR. GRAY: Thank you, Your Honor.
THE COURT: Mr. Gray?
MR. GRAY: Thank you, sir.
BY MR. GRAY:
Q Doctor Saleh, you gave a diagnosis of antisocial personality disorder to Mr. King, isn't that correct?
A That's correct.
Q And antisocial personality disorder has been recognized as a serious mental illness for the purposes of certification of sexually dangerous persons in Massachusetts, isn't that correct?
A You know, I'm not sure.
Q Doctor, are you familiar with the case of Commonwealth versus Reese?
A I don't remember, no.
Q It is a case that discusses the use of the term antisocial personality disorder, and it's a case in which the Supreme Judicial Court of Massachusetts opined that a diagnosis of APD, antisocial personality disorder, is adequate to satisfy the definition requirements. With that additional information, does that assist you in recognizing or understanding the facts of that case?
A Absolutely not. I mean, you're just telling me what the court ruled. I understand that the

Massachusetts statute talks about the respondent -- I mean, the definition would be that the -- either mental abnormality or personality disorder, and personality disorders is defined as a condition -- statutory defined where they have a general lack of control to their sexual impulses or something along those lines, and that's what I can say in terms of the statutory definition. Again, I'm not familiar with this case. I don't remember the case.

Q And are you familiar that the First Circuit in the United States versus Carter also found that antisocial personality disorder would qualify as a serious mental disorder under 18 USC 4248?

A Again, I'm not an attorney, and I'm aware of some of the statutes. I don't remember the case you mentioned, and I certainly don't have any reason to believe that what you say is incorrect.

Q Doctor Saleh, a percentage of your practice is clinical work, isn't that correct?

A That's correct, yes.

Q In fact, part of your clinical work involves those who have sexual behavioral issues, isn't that correct?

A Yes.

Q Doctor Saleh, if I could pose a hypothetical to

you, if a patient were to come into your clinic and state to you that they had feelings in which they wanted to go out and kill somebody and they felt like a hibernating bear, you would feel compelled to take action on that, wouldn't you?

A Depends how you define taking action on it. I mean, if somebody comes in with that and so that's the first time I see this individual, he walks into my office and that's the first statement to me with no other records in front of me --

Q Well, we'll use that as the beginning portion of this hypothetical, yes.

A Well, I have to tell you it would be very unusual for somebody to just walk in and then make that statement, but hypothetically let's say if that were the case, would I say to them thanks for sharing this information with me and I will see you in one month for follow-up visit? Probably not. Would I want to talk to them more in-depth? Absolutely. Would I want to get a better sense of their -- whatever their statement means, where that comes from, understanding the context? Absolutely. Would I like then to corroborate the information via other records or documents? Yes.

And would I take action, as you said? I certainly -- what I wouldn't do is I wouldn't just

discharge or dismiss that statement. The action would be that I would try to get corroborating information, and I may or may not take action, which could be sending the patient to the emergency room for further evaluation if indicated.

Q But you just wouldn't disregard that comment completely?

A Absolutely not. I mean, nobody, I think, in their right mind would just disregard a comment made to you of this nature.

Q And if this were a continuing patient of yours that you had been seeing for a number of years and this patient had a conviction for assault, assault with a deadly weapon, carrying a deadly weapon as well as has been known to expose themselves in the past and they came up to you and said I feel like I'm a hibernating bear who has awakened with a desire to eat and eat he will, you'd take that comment seriously, wouldn't you?

A -- tell you this. You take it seriously, but it doesn't mean necessarily that you act on it. I have patients who come in and do report -- actually, let me see if I can give you an example -- of a person who did report that he had thought of going out and killing little children, and so I certainly wouldn't dismiss it. By no means would I dismiss it, and I would consider

that, but, again, the thing is you have to put it back in context, understand the motivation behind that information.

So if this is somebody who came to my office and everything that I would have at my disposition, reports from people, family members, other psychiatrists, over 40 years and everybody would say that this man has never lied, was always honest, shared his emotions and feelings in a truthful manner, has sought out treatment voluntarily to get help and do -- well and doesn't present with anything that would remotely be close to psychopathy or antisocial personality disorder or malingering, I certainly would take that account into consideration and give it the due weight it would deserve.

Yet if I take into account what I have in front of me, because that's -- statement from Mr. King, it's a serious concern. It's certainly -- statement that raises anyone's eyebrows, but then if I put it back into the context and see what type of things he has reported over the course of his lifetime, including that he has alters, including that he has offended because of a blackout and it wasn't actually him offending during the blackout, but it was one of his alters, and if I have this man telling me that he hears voices, that he has

thoughts of killing himself, yet he didn't have any thoughts or plans of killing himself, that's a context -- again, if you just take -- in a vacuum and present to me the concern would be there, but I can't look at things in a vacuum and fit back into the context.

Q Now, you're aware that Mr. King made various claims that he was seeing -- he had voices in his head, that he had -- also had multiple personalities and that led to some diagnoses that were made about Mr. King?

A Yeah.

Q What were those diagnoses?

A Well, let me look at my report. I mean, I have a list of a few, but I can certainly give you a few. One would be schizophrenia, that he carried a diagnosis of psychosis, anxiety disorder, mood disorder, antisocial personality disorder, exhibitionism,

Then intermittent explosive disorder, substance abuse, dissociative personality disorder, multiple personality disorder, I believe even borderline personality disorder, if I'm not mistaken, bipolar disorder, malingering. That's what I remember of him.

Q But he was diagnosed with malingering after the folks at Butner determined that he was, in fact, lying and was not truthful about his multiple voices, the

additional personalities and even some of his suicide attempts, isn't that right?
A The issue of malingering, I mean, he was -- and I have to tell you I would have to go through the entire records to say when they first said or raised the issue of malingering, but I do know that he was said to malinger -- I mean, as you pointed out, at subsequent -- at least at one point in time to the -- when he was talking about the multiple personality disorder, all this was --
Q So you would agree that the record at least indicates that some of his behavior in terms of lying about various disorders was actually recognized by some of the psychologists?
A Well, again, you're picking things and choosing things here. I'll tell you this.
Q I'm sorry, Doctor. If you could just answer that question, then feel free to elaborate --
A Sure. The answer would be yes.
Q Thank you.
A And the point you make is you can't just when you have the records in front of me ask -- just take that into consideration as you did previously with the exhibitionism diagnosis he received in 1976 and disregard everything else. The point is that's why you

have clinical data and clinical records on a person is to understand the case.

Was he diagnosed at one point in time with atypical psychosis? Yes. Was he said to suffer from dissociative personality disorder? Yes. And if you look at the records, the therapist or psychologist at that time believed that he has this personality or this dissociative personality disorder because what he said is -- let me just tell you -- because I thought that was quite telling.

Here we are. So he described -- I'm not sure if that's the section, but what I have highlighted is it says, for example, he described hearing voices, one male and one female and maintained that it was one of these personalities, Ken or Kirsten, that are present when he loses time.

And then they went on to say that initially he was unable to tolerate the surfacing of strong emotion without defending either -- avoidance or dissociating. Over time, sadness has become more accessible to him. Anger remains difficult for him to express without dissociating.

In general, the personality of Ken is the keeper of anger and aggression. Ken presents himself regularly in session. Kirsten expresses the need for love and

affection. She has never presented herself as -- if you read this piece, you really wonder what was going on. The mastery of manipulation, it's really -- it's right in front of you.

I mean, how much -- what did Mr. King do to persuade this Phipps psychologist to even believe and write down what he wrote down what we have in front of us? That's -- if you think about this today, it just doesn't make sense. You wonder where -- how could somebody draw those type of conclusions, believing in Ken, Kirsten and all that stuff? That's manipulation.

And, again, the point is of malingering -- it goes hand in hand with manipulating the system for some ulterior gain he may have, and he certainly got the attention he needed at that time when he was making these statements and presenting himself as being somebody else and having these personalities.

Along those same lines --

THE COURT: Doctor Saleh, let me -- I'm going to interrupt you, and I want to make a comment to you as well as Mr. Gray. When he asks you a question, I would request that you answer the question that is asked. If it's a yes, no question, you may respond. I would appreciate it if you respond yes or no, and then you may explain.

Unless he calls for specific examples and recitation of excerpts from the record, I'd prefer you not do that, just because if we continue at this pace, we're going to be here until the evening. If he wants to elicit that information from you, he can ask you that.

If Mr. Bell thinks that something important has been left out, he's going to have a chance to come back to you and elicit that. So you'll have a full opportunity to express your views, to the extent you already haven't had it.

I think some of these questions we're just -- we're retreading ground that's already been covered. We don't have a jury here. I think Doctor Saleh has been very eloquent and thorough in his responses, so I don't think there's a need to retread ground that's already been covered, Mr. Gray. So if you could limit yourself to new material, I would appreciate it.

MR. GRAY: Yes, Your Honor -- certainly my intention.

BY MR. GRAY:

Q And, Doctor Saleh, in fact, after that revelation of Ken and Kirsten, isn't it true that Mr. King was then sent to Butner for further evaluation, and then your report at page nine, you note in that report that they found out and said he wasn't believable?

Isn't that true?
A Yes.
Q Now, with regard to Mr. King's conduct involving drug use, you on your report on page -- if you would, please turn there with me to page 16 at the bottom where it says speech and thought.
A Yes.
Q It states that in that first blotted -- it says Mr. King's speech was regular in rate, normal in tone and value, and then it says he denied obsessions. So you asked him that question?
A I asked about intrusive thoughts he may have had, yes.
Q And he denied those?
A He denied them to me when I asked him that question.
Q And you asked him about compulsions, and he denied those as well?
A When I asked him the question at that time, yes.
Q And asked him about phobias, and he denied that as well?
A Yeah, sure.
Q And you also asked him about paraphilic disorder related symptoms such as deviant sexual thoughts, fantasies or behaviors, and he denied all of those to

you as well?
A That's correct.
Q And when he denied all those things, you relied upon those statements, isn't that true?
A No, that's not true.
Q And further on in that paragraph, it says you did -- Mr. King told you that he did multiple personality disorder thing, that he attempted to do the massive depressive thing -- manic depressive thing and being suicidal and he did it to better living conditions and to get attention, isn't that right?
A That is what he told me, yes.
Q And he also told you that he had BS-ed these people so many times, I thought I was doing the right thing trying to let them take care of me, isn't that right?
A That is what he said, yes.
Q And on page 17 in the diagnostic opinion, at the very bottom of the second paragraph in that line, you write the data with regard to paraphilic disorder diagnoses are inexistent?
A Yep.
Q So you didn't find anything that would support a paraphilic disorder within the records that you reviewed for Mr. King?

A Let me just see. Actually, what I said is -- you omitted one piece of what I said. I said in fact, with the exception of Mr. King's behaviors in the mid '70s, 1970s, the data with regard to possible paraphilic disorder diagnoses are inexistent.
Q So there's nothing in the record after the '70s that would indicate that he's got a paraphilic disorder?
A There is nothing in the records since the mid 1970s that would suggest or support the notion that he suffers presently from a paraphilic disorder, however you were to define it.
Q Doctor Saleh, you're familiar with the DSM-IV casebook, aren't you?
A Yes.
Q That's a document or that's a book that's relied upon by those within your field, isn't that right?
A It depends. I mean, as you know, some people rely on certain things. Other people don't.
Q And it's also known as being a learning companion to the Diagnostic and Statistical Manual for mental disorders?
A Yeah.
Q And within that casebook, there are scenarios that are used to help make diagnoses, isn't that right?
A I haven't looked at it for a while, but if

that's what you say, it probably is accurate.
Q And in the diagnostic casebook,
if I could read you this hypothetical --
A Yep.
Q Growing up, often feeling alone and unloved, he began fantasizing about the perfect relationship with an ideal woman who -- could sweep her off her feet. As time passed, such fantasies and urges began to assume an eroticized obsessional quality. Initially he would imagine himself coercing an unwilling woman into sexual activities that she would then come to enjoy. He would then fantasize of a -- caring relationship. Often he would masturbate while having these fantasies. Though Jim understood that the scenario in these fantasies was unlikely, he nevertheless began to be preoccupied with sexually exciting urges to act upon these fantasies.
When he was 16, he committed his first rape, and after each rape, he would promise himself never again, but in time as his preoccupations and urges were rekindled, he would repeat the cycle. Although he would often threaten women with a knife to obtain their compliance, he never physically hurt them and used minimal amount of force necessary. Any obvious signs of suffering and anguish would diminish rather than enhance his erotic arousal. During the course of each rape, he

would invariably throw away his weapon and assure the women that he did not intend to injure them or cause them harm.

When reading magazines or watching movies depicting scenes of females in positions of subjugation or bondage, he would become erotically aroused, fantasizing that they were enjoying the experience, but he would not become thus aroused if the women seemed to be suffering or in genuine distress. Apart from his conviction for rape, Jim has never been convicted or accused of any other type of criminal activity. He has no history of outpatient or inpatient psychiatric treatment. He was stable at work. He has a stable work history. He has never abused alcohol and other drugs.

Now, with regard to that hypothetical, the DSM-IV casebook says however, this rape behavior can best be understood as a manifestation of a specific paraphilia because the erotic arousal depended on having a nonconsenting partner. During the development of the DSM-III-R, the term paraphilic coercive disorder was suggested for this particular type of paraphilia, but this category has never been officially recognized. Therefore, Jim's disorder would be coded as paraphilia not otherwise specified, DSM-IV. Would that be

consistent with your training and understanding as to how a person with that sort of past background should be characterized?

A I'm not sure if I fully understand that question in terms of characterize. I mean --

Q Is paraphilia NOS a proper diagnosis for that hypothetical?

A NOS for that hypothetical? It depends. I mean, again, you just read me a one page document and you're asking me if I would consider paraphilia NOS as a proper diagnosis for this hypothetical. I would have to say it depends, and one has to look at the differential diagnosis.

Would I consider it and would I consider sexual behaviors of a violent nature? Would I consider a paraphilic disorder diagnosis? Yes. I mean, in terms of the differential diagnosis, but would that be -- appropriate diagnosis I would give to this hypothetical, what you just read, I don't know without knowing more about the case.

Q If you were to learn -- and if Mr. King were not diagnosed as being a chronic liar or pathological liar, would Mr. King have the diagnosis of paraphilia NOS?

A Actually, I was told -- I mean, what pieces of his records would you want me to rely on? The things he

acknowledged at one -- at one point in time or things he dismissed at another time? Do you want me to acknowledge when he said all these -- things about him or Marlene King was responsible for his behaviors? If you could be more specific -- what element of the record do you want me to consider? That heroin did help him to avoid acting out or amphetamines drove the behavior? I mean, I have to tell you, that question I don't think I can even answer. You have to give me a more specific -- I mean, you have to provide me with a better question.

Q Fair enough. At the bottom of page 16 of your report, Doctor Saleh, in the line where he was recounting to you I BS-ed these people so many times, I thought it was doing the right thing trying to let them take care of me, right after that line, he states I can do it on my own, I'm fine. My question to you, Doctor Saleh, is can Mr. King do his treatment on his own? Is he fine?

A Actually, I don't think he was referring to treatment, so -- he was not referring to treatment.

Q And is he fine?

A Depends how you define fine. I mean, what do you mean with fine? I mean, is he fine in what regards?

MR. GRAY: No further questions.

THE COURT: Mr. Bell?

MR. BELL: Thank you, Your Honor.

EXAMINATION

BY MR. BELL:

Q Doctor Saleh, earlier in your testimony there was discussion about the APA's stance with regard to sexually violent person or sexually dangerous person statutes. I think the Government attorney read some documentation related to their resistance or their -- actually, I believe you indicated they filed amicus briefs in Supreme Court cases related to that, isn't that correct?

A That's my understanding.

Q I just want to clarify. I believe you testified, and correct me if I'm wrong, that you do not personally as a psychiatrist necessarily have any sort of bias against sexually dangerous person or sexually violent person statutes per se, do you?

A No, I don't.

Q I believe your testimony was that as long as the evaluators adhere to the proper principles in conducting their evaluations and arriving at their diagnoses, it was fine and proper if someone was determined to be a sexually dangerous person or a sexually violent person, isn't that correct?

A Yes. I mean, the bottom line is the foundation

that would allow me to then apply empirical information or the database on the statute. So if my foundation is flawed and I make things up while I go along, try to find something to make my case and then apply that elicited clinical information on a legal statute, that's where the problem is, and then that's -- misleading the trier of fact. It's like the not guilty by reason of insanity defense -- I do -- you have clinical data, look at the clinical data and then apply it to the statute and address a legal question where the court allows you to do it, but the, I think, at least expertise of the forensic psychiatrist is -- we need to provide the court with the clinical data unbiased as they present themselves and then apply it, but ultimately that's a legal process one has to go through.

Q And you've had any number of cases where you've evaluated an individual, an inmate or an offender where you have determined that, in fact, they did fall under the statute, the sexually violent person statute in Massachusetts or where have you, haven't you?

A Yes, absolutely. The cases I have done, I have -- both for the prosecution. I mean, I have done cases where I wrote a report stating that in my opinion to a reasonable degree of medical certainty that the respondent meets a sexually dangerous person definition

as defined by the Massachusetts statute. I have wrote it, reported back to the attorney or the office who retained me on the case. I have reported back to attorneys, defense attorneys stating that I read the records, that in my opinion the person meets that definition and that I couldn't assist them, and I have done the contrary.

I reported to the prosecution that a person doesn't meet the definition, and the same is true for defense attorneys, the person doesn't meet the definition under SVP --

Q Now, there was a lot of testimony earlier about this diagnosis of paraphilia NOS, nonconsent or label, whatever you want to call it, the fact that it does not -- is not contained in the DSM-IV-T-R, and you indicated that there was no empirical evidence to support the diagnosis and so forth.

The diagnoses that do end up in the DSM-IV-T-R, if you would briefly -- I don't want to get into a long diatribe about it, but just briefly explain to The Court the sort of vigorous debate and research and so forth that goes into how something ends up in the DSM-IV-T-R or DSM -- manual briefly.

A Yep. I'll do it as briefly as possible. So the way -- goes about it, there is a database on a given

proposed condition in terms of articles, studies, research, and then it's presented to the taskforce, for example, and that is looked at, and then over the time it's -- decision that is not made over a week or so, but over a certain time period. There's further information pertaining to a given diagnosis that is looked at, as you pointed out, debate -- debated, discussed, and only if it meets a standard of it being a valid scientific entity, it will make it into the diagnosis.

Having it in a back page of the DSM, I think that is what that would be or would -- considered to be. That's not the way the diagnosis works. In order to make it into the DSM, there needs to be a robust foundation behind it. Otherwise, it's not going to be introduced. And the fact that the DSM for 30 years now has rejected the paraphilia NOS, nonconsent, it actually notes that the NOS non -- so the paraphilia NOS category shouldn't be used as a proxy for the nonconsent diagnosis. There is a reason behind it, and the reason is because there's no scientific evidence supporting these conditions and, therefore, it doesn't make it into the DSM.

Q There was some testimony earlier in the week, Doctor Saleh, related to self-reporting by Daniel King, and it's in the record, about the heroin use to dampen his drive for sexual acting out and so forth. Was it

important in your assessment of Mr. King that he had, in fact, not tested positive for opiates or heroin since he had been at Butner? And I believe he went there in May of 2009 and yet there had been no incidents at least in the record of sexual misconduct. Was that important to your decision?

A Yes, absolutely. I mean, that's, again, one of those points where you have somebody who is -- if the urine toxicology screens are accurate has used heroin. There is testimony or at least I understand somebody suggested that the heroin or -- was used to dampen the sexual drive so that that helped him not to act out sexually. And say so far we take this as being fact, and what we do know is that Mr. King has not acted out sexually with the exception of the 1993 incident when he approached a person and this alleged -- whatever was alleged earlier that may have happened yesterday, last night.

The question boils down to so if I say heroin helped him not to act out sexually, that was a treatment that helped him to stay away -- of -- stay out -- control, the question that I would have -- would ask myself as the expert is what's the half-life of heroin, how long does it stay in your system and what does it do to you, because that's a relevant question, because my

understanding is that Mr. King has not used heroin every single day, three times a day because -- only this way one could be assured that it's indeed in his system, that he builds up a steady -- level and operating under the assumption that that would allow him not to act out sexually.

Heroin doesn't stay in your system for more than a few hours. My understanding reading the records is that he has not used heroin every single day, several times a day, and urine tox screens over the last years at least the tox screens I saw -- we have only a handful of toxicology screens that show that he had used heroin and he has not used heroin -- last two years, since 2009. I would have then to go back and explain how it is possible if the theory of heroin being the damper of sexually out acting out behavior -- that he has not acted out sexually during the time periods in between the heroin -- you had positive urine toxicology screens -- the last two years.

So that hypothesis of heroin being the solution to his behavior, sexual behaviors and impulsivity becomes nullified because it doesn't -- I mean, I can't -- yeah. I mean, I wouldn't be able to conclude that that helped him to -- behavior, appropriate -- not to act out sexually, because what about all the other

days and times while he is in the prison system where he has not acted out sexually and it was not related to -- heroin? So it doesn't make sense, that analogy.

Q Now, just a few moments ago, Mr. Gray related or pointed to a statement or a -- I guess a statement of Mr. King in quotes and asked you whether or not you relied on that statement from his interview in arriving at your determination or evaluation, your ultimate opinion about Mr. King. Explain again briefly to The Court exactly how you used his statements that -- that you didn't totally disregard them, but you used them in terms of the context of the overall record. Just briefly explain that to The Court again, how these statements were useful to you in your evaluation.

A His statements to me?

Q Yes.

A Well, I wanted to hear his side of the story at that time, and that was, I think, the extent of what I was able to get is his side of the story, and, again, I'm not sure if I totally understand your question in terms of --

Q Well, I think that the impression from the question from Mr. Gray was that you totally disregarded what he told you in the interview. I may be misstating, and if I am, I'm sure I'll be corrected. I don't think

your testimony was that you totally disregarded his statements or didn't take 'em into account but that you took 'em into account in the context of the overall record, and I'll just ask you to sort of explain to The Court again briefly sort of how you did that.

A So the one thing I can say is -- take the example I think that was brought out earlier about the obsessions. So if I ask somebody if they have an obsession, I don't just ask do you have an obsession and then go with the answer. What I try to do is elicit -- is the description of what they describe as being an obsession consistent with what I understand the obsession to be. Is this a way an obsession would present itself in a person presenting with, say, a sexual disorder or obsessive-compulsive disorder? I to get a description of the phenomena he at one point in time is reported to have experienced.

Same thing with hallucination. So he may say I have heard voices in the past. If I ask him tell me about that, how does it present itself, what was it like, and if he gives me the description as I heard earlier that it's a voice in my head and that's -- and then if I were to conclude that's a hallucination, that would be incorrect, because a hallucination doesn't work like that. So I try to get a description from him to

suggest -- well, to support one or dismiss the condition of, say, psychosis that he was given at one point in time.

His descriptions of psychosis or hallucinations were inconsistent with what I know and understand how hallucinations present themselves in patients truly afflicted with a psychotic illness. And so, I mean, in this way -- and that's -- much of the time we spent was going through these phenomena trying to see if they're actually consistent with the pathology, the phenomenology of these conditions, and they were not, and, therefore, I would agree with the fact that presently the fact that he doesn't have a clinical diagnosis by -- or doesn't carry a diagnosis by his current providers makes sense, that there is no diagnosis of schizophrenia or bipolar disorder because he did not report anything that would be remotely close to that condition the way at least these conditions would have to be diagnosed.

MR. BELL: Nothing further, Your Honor.

THE COURT: Mr. Gray?

MR. GRAY: No, Your Honor.

THE COURT: Let me ask you, sir, if I could, just a couple of questions. Is my understanding correct that in evaluating a person who has been in prison,

particularly one for an extended period, that that fact that they have been in a prison environment would be considered in an evaluating a conduct?

THE WITNESS: Yes.

THE COURT: Say you're trying to evaluate whether a person has a paraphilia. How would the prison environment affect the analysis? And what I'm specifically wondering about is if you are in a controlled -- if the patient is in a controlled environment like that where there may be fewer opportunities to act out, so to speak, how does that figure into the analysis of whether the person would have paraphilia?

THE WITNESS: I mean, in terms of -- let me see how to explain it. If you are in a controlled environment, he has not the same amount of opportunities he would have if he were in the community.

THE COURT: That's exactly what I was getting at, yes.

THE WITNESS: And so the question then is how do we know that it's the environment that is prohibiting him to engage in paraphilic behaviors he presents with but they're not manifest because of environment.

THE COURT: Right.

THE WITNESS: Okay. So the answer to that

is -- if I may break it down --

THE COURT: Certainly.

THE WITNESS: -- so I can explain, the first thing I would do is with Mr. King, we have not just a one year prison term we're looking at, but years of prison time, so he has been -- he has gotten used to the environment he is in, has adjusted, and in that context has engaged in behaviors that are considered against the rules of the prison environment -- and procuring all the drugs he has procured over the course of these years. So he has -- despite the fact that he is in this controlled environment, he ended up having urine toxicology screens positive for heroin, so it didn't deter him from engaging in ultimately -- I don't know if it's criminal behavior, but at least behaviors that are not sanctioned within that setting. That's one.

The other thing I can point out, that despite the fact that he is in a prison environment, controlled environment, his sexual drive has remained and he has been sexually active as he has been previously prior to Coming to the prison environment. He has had relationships with, for example, the inmate, Smith, where they were considered a couple. He had strong urges for him, and so he has established relationships, homosexual relationships with at least this one inmate I

know of offhand.

And his sexual interest is geared towards men, and if you say -- even disregard the issue of sexual orientation but say that he is an opportunist and is going to be sexually involved with men because these are the only people he can have sex with, and if he truly had a paraphilic disorder where he would again have to establish that he has these intense urges -- I mean, we talk about the intense urges that -- people, if they truly suffer from it to act out, I would expect to see something in the last 30 years within the environment he has been in where you would say that this man has indeed -- because ultimately untreated, he has not been on -- no medications -- you treat a paraphilic disorder.

So you have somebody with an untreated paraphilic disorder in this environment where there are stimuli because there are female staff, male staff, inmates he has sex with, yet there is no sexual acting out behavior other than the 1993 incident where he proposed somebody to touch his penis and nothing else happened, and that's where I think that doesn't go hand in hand with -- paraphilia diagnosis, however one were to define it, because if I truly suffer from this condition, I can't just turn it off and say because I'm

in this setting, I'm not going to have this drive or interest.

And the way to think about this is appetite for food. I mean, it's -- sexual drive is a physiological drive that requires excitation and -- and people within this human response cycle, sexual response cycle, they get excited, they engage in sexual behavior. Then there's a resolution phase and they start all over the cycle of sexual activity. And with a person with a paraphilic disorder, the difference is that their target of their sexual interest is paraphilic. For example, the person with pedophilia that -- they're interested, for example, in children.

Now, with Mr. King, his target has not been children. If one were to say that his interest is having coercive sexual acts or being aroused by the coercive nature of the sexual activity, he would have opportunities within the system to engage in that behavior, and specifically if these symptoms were as intense, because you can't just turn it off and say well, I'm not going to act on these impulses because I'm in a prison system in the absence of any treatment or medications.

And so I think it's really this negative here that we have, lack of data supporting a paraphilic

disorder diagnosis that wouldn't allow me to draw the conclusions within this setting or even outside this setting in the community to say that his behaviors are that of a patient or individual with a paraphilic disorder.

If I could just make one last point maybe to be even clearer is if I tried to diet and I say I'm on a diet and I have to lose weight, I may have the best intentions to lose weight. Come six p.m., I'm going to be hungry and I will succumb to the urge and will open the door of the fridge and will sneak into the kitchen and eat something and will be upset later on, but I give into this physiological drive which is appetite for food and ultimately end up not adhering to the diet.

Sexual drive, if it's as intense as required by the DSM and it's paraphilic in nature, you would expect something somewhere, but in the absence of any data supporting that, again, from my viewpoint, there is no evidence to support this paraphilic diagnosis at this time.

THE COURT: Very good. Thank you. Mr. Bell, any follow-up?

MR. BELL: No, sir, Your Honor.

THE COURT: Mr. Gray?

MR. GRAY: No, Your Honor.

THE COURT: Very good. You may step down, sir. Mr. Bell, is there any other evidence from the Respondent?

MR. BELL: There is not, Your Honor. We would like to hold Doctor Saleh in reserve in case we need to bring him back on -- rebuttal. I assume that they are going to have a rebuttal witness, but other than that, we have no evidence at this time.

THE COURT: Okay. Very good. Mr. Lockridge, sir, is there any rebuttal evidence?

MR. LOCKRIDGE: Just briefly, we'd like to reoffer Doctor Zinik on rebuttal.

THE COURT: That would be fine. You all settled, Doctor Zinik?

THE WITNESS: Yes. Thank you, Your Honor.

THE COURT: Okay. Very good. Let me remind you, sir, that you do remain under oath.

THE WITNESS: Yes, Your Honor.

THE COURT: Very good. Mr. Lockridge?

MR. LOCKRIDGE: Thank you, Your Honor.

EXAMINATION

BY MR. LOCKRIDGE:

Q Doctor Zinik, I hope to keep it brief. You heard Doctor Saleh's testimony here today?

A I did, yes.

Q And his -- also with regard to his testimony with regard to the use of actuarials?
A I did, yes.
Q And is it your opinion -- or what is your opinion with regard to the -- your use of the actuarial instruments that you used as to their -- whether they have been reviewed and accepted among your peers?
A Well, it's my opinion that the actuarial scales I use, the -- the Static-99, the MNSOS -- and the Static-2002R are accepted within the professional community. I think I mentioned that this is the direction that the field of civil commitment is moving toward. This is becoming the standard of professional practice, using actuarial scales as a component of risk assessment.

In fact, there are some states -- I understand that the State of Texas actually requires the use of the Static-99R. I know that California is using the Static-99R at several points prior to parole of sex offenders, and I don't know if it's required by SVP evaluators, but it is highly recommended that the SVP evaluators on the Department of Mental Health use actuarial instruments.

I have a five page bibliography here of dozens of studies. These are cross-validation studies or what

we call replication studies. The majority of them apply to the Static-99R. There is no question that these instruments have been validated and cross-validated across many samples of sex offenders, but particularly the Static-99, it is used all over the Country. It is -- there are cross-validation studies from Germany and foreign countries, so I think there's plenty of evidence that these scales are valid.

The way -- now, what that means is that the -- the sorting value of them, that they're useful and they are valid and the results are replicated across different samples and different countries for sorting sex offenders into low, medium and high risk categories. They show, you know, continuous at least moderately high levels of validity for that purpose.

Where you run into difficulty with the actuarials -- and I do agree with Doctor -- if it's Saleh or Saleh, forgive me, I'm not sure what the correct pronunciation is. I've heard both, but there is a lot of controversy over them. There is a base rate problem, which means that the actual reoffense rates of the offenders varied from sample to sample. Those do not remain constant, so it is important to try to match your case as accurately as you can to the sample of offenders that you feel they're the most closely compared to.

Otherwise, you may have -- you may be off in terms of these predictions of rates of recidivism.

So, you know, I think you do tread into more controversial waters when you try to make statements such as, you know, Mr. King would reoffend at a 50 percent rate within ten years. You know, these are statements that -- you know, I would not make a statement like that. I mean, we don't know. Again, we're applying group data to an individual, and all we can say is that, you know, based on the offenders in the original developmental sample of this instrument who scored similar to Mr. King, that that group reoffends at a, you know, 25 percent rate in five years or whatever it might be, okay?

But I think that -- I mean, actuarials are here to stay and they are becoming more widely used. The Association for the Treatment of Sexual Abusers, the ATSA organization that Doctor Saleh referred to, his -- they have a policy paper on their website where they recommend the use of actuarial instruments for the civil commitment evaluation risk assessments, so, you know, I just think that -- and the purpose of this is to try to make our efforts more scientific.

You know, this is -- I think the caveats are important. You know, this is not rocket scientists --

this is not rocket science. These are not infallible instruments. There are margins of error, but I think they are good enough. They have been proved good enough over the last ten years or 15 years that they are worthy of using and they are being used more and more, so, I mean, I would certainly support the use of them in a case like this.

Q Doctor Zinik, did you hear the questions and answer regarding the use of the DSM-IV-T-R casebook?

A I did, yes.

Q Are you familiar with the scenario that was --

A I am, yes.

Q -- testified to?

A Yes.

Q Could you just briefly, I guess, restate the scenario as you understand it that -- the scenario that's in the DSM-IV-T-R casebook?

A Okay. Well, this is a casebook that is published by the American Psychiatric Press which publishes the DSM manual and it is designed to be used in conjunction with the DSM manual as case examples of how to diagnose these different disorders, and this is a book in which there is a case and it's referred to -- it's called the Perfect Relationship. I think that's the title of it, and that's how it's known among the professionals in the

filed.

Anyway, we call it the perfect relationship, and it was a fellow, Jim. I think Mr. Gray read the story. This is a real person, a real living person who -- as a matter of fact, he is a patient of Doctor Fred Berlin, and Doctor Berlin wrote up the case example, and this is -- actually, the same case example word for word verbatim was also reprinted in another paper by Doctor Berlin in the Journal of Sexual Addiction and Sexual Compulsivity in 1997, so it's been reprinted in a couple different places.

In fact, I was at the ATSA conference last October in Phoenix and went to a training provided by Doctor Fred Berlin, and he showed a videotape of this patient. His name is Jim, and he talked about how he would masturbate thinking -- you know, he had sexual fantasies about raping women, and he started raping women when he was 16. He actually observed his father raping women, and that was one of the first exposures to that experience he had, and it was sexually exciting to him when he -- and he tells the whole story.

I mean, this is a living, breathing example of a rape paraphilia. This guy is in prison now and has been for I think about 25 years. It was one of the early cases of Doctor Berlin's. In the videotape, you see both

of them as young men, and now they're, you know, 25 years older, but, you know, my point that I do agree with some things that Doctor Saleh said, but there's one thing I disagree with, which is if I think -- if he said -- if I heard correctly that he said that the -- I mean, yes, he's right that the language is messy. There is no standard terminology to diagnose this condition. That's a problem.

You know, I use the term forced sex with nonconsenting females. That term does not appear in the DSM, that is true. Those are the qualifiers I used after the paraphilia NOS diagnosis, which does appear in the DSM. Paraphilia NOS is the beginning of the appropriate diagnostic term, but there's no standard qualifying terms or specifiers that are in use. Unfortunately, that's a problem, but if you were to say that the condition does not exist, if you were to say that there's not a single sex offender out there in the whole world who is not -- who is sexually aroused by forcing women to have sex with him, that statement is not true. I mean, those people exist.

I have -- I mean, I can think of half a dozen of them off the top of my head that I sat across the table and talked to them, and they will tell you sometimes they have to be in treatment for a period of time before

they're willing to fess up and talk about their private sexual fantasies and masturbation habits and those kind of dirty, private secrets, if you will, but there are -- sometimes, you know, you get an honest guy who will say this is what turns me on, this is -- you know, I masturbate at night to fantasizing about raping women and I've been doing this since I was 14 and I have raped, you know, 20, 30 victims and I -- you know, one of my most exciting sexual turn-ons is to break into a woman's home at night and sexually assault her. And, I mean, these kind of serial sex offenders do exist. We have some good case examples, and there's also some empirical evidence to support their existence.

Now, this is -- see, one of the problems is it's so hard to do research with -- on this condition because it's -- you know, you don't get many sex offenders who are willing to talk about their private masturbation fantasies, for one thing. You don't get many sex offenders, many rapists who are willing to participate in the plethysmograph evaluations that I was talking about earlier.

Now, remember, this is one area of inquiry into the -- where there's some good new empirical research that's coming out about the -- you know, the existence of forced paraphilia for -- forced sex. It's not very

clear-cut, because the samples are small. You know, we've only got small groups of incarcerated rapists who are willing to submit to these plethysmograph evaluations, but there's certainly been some spirited debate in the academic press.

There are a couple experts. There's Doctor Raymond Knight. There's Doctor David Thorton. There's Doctor Martin Lumiere. (phonetic)

Q Doctor Zinik, I'm sorry. Not to interrupt --

A Okay.

Q Unless you had something else to say that's pertinent, I think that you've answered the question.

A Okay.

Q I appreciate that.

A Sure.

Q Getting back to that casebook, the DSM-IV-T-R casebook, under that scenario, what did the authors of the casebook indicate the proper diagnosis for that case was?

A Paraphilia NOS.

Q Is that what you diagnosed Mr. King with?

A Yes, but I added some specifiers, yes.

MR. LOCKRIDGE: No further questions, Your Honor.

THE COURT: Thank you, sir. Mr. Bell?

MR. BELL: Briefly, Your Honor.

EXAMINATION

BY MR. BELL:

Q Doctor Zinik, your testimony on Monday, you indicated that you do quite a bit of work for the California Department of Mental Health, is that correct?

A Yes.

Q I'm going to read to you from an article that we pulled from the Psychiatric Times related to -- well, the title of the article is Another Step Toward Ending the Paraphilia NOS Fad, the California DMH -- which stands for the Department of Mental Health -- Takes a Stand. Are you familiar with this article?

A Yes, I am.

Q So you would know that in the article it basically states that paraphilia NOS, nonconsent has received two devastating setbacks -- two of the three strikes that be will necessary to finally knock it permanently out of the box. Are you familiar with that statement?

A Yes.

Q The first strike came with the DSM-V decision to reject the ill-conceived proposal for a new diagnosis of coercive paraphilia. Are you familiar with that?

A Yes.

Q The next step discussed below, which we'll get to, has come from the California Department of Mental Hygiene, which is the department you do some work for, correct?
A Yes. Well, no, no.
Q I mean mental health.
A Yeah. That's the wrong term.
Q -- which has instructed state SVP/SDP evaluators, which you're one of, correct?
A Yes.
Q -- to end their careless misuse of the paraphilia diagnosis. The third and final strike will hopefully come soon when paraphilia NOS, nonconsent is finally ruled inadmissible as expert testimony, a move that surely makes great sense, given that this diagnosis does not meet the expectable standards of competent, much less expert psychiatric diagnosis. Are you familiar with that statement in this article?
A Yes.
Q Further, the California DMH took the latest and giant step forward in ending the paraphilia NOS fad recently. State evaluators were recently summoned to an SVP training workshop where they were explicitly instructed to adhere closely to the intent of the DSM-IV and to desist from making idiosyncratic paraphilia

diagnoses. Are you familiar with that?
A I've read the article, yes.
Q Did you actually go to one of these training workshops?
A No, I did not go. I was not there.
Q Now, you talked about the risk assessment tools and the actuarials, and I believe you agreed in your testimony on Monday and you reiterated it today. I don't want to belabor the point, but they are limited in their use, there is some subjectivity involved with taking a offender and placing them in a particular comparison group. You agree to that, correct?
A Yes.
Q And you have to take that individual's characteristics as they're presented to you in the record, use that information in putting them in a comparison group, correct?
A Yes.
Q And that is a subjective determination made strictly by the evaluator, correct?
A Well, this new SRAFV is an instrument that is designed to try standardize that method, that is correct, but there is some even within that -- scoring that, there's some subjectivity. You have to use the records and, you know, decide what you consider

important and so on.
Q And you would acknowledge that in this particular case with Mr. King, that's what you did, you looked at the record, his criminal history, his records of mental health treatment, his self-reporting and all of those things, and that's what you used in determining that he was in the high risk, high needs comparison group, correct?
A Yes.
Q And would you acknowledge that again -- and I think you stated it earlier that these tools are not designed nor are they accurate in saying that a particular offender is going to have a particular likelihood of offending at a particular rate in a given period of time. Is that a true statement?
A Yes.
Q Now, this DSM-IV-T-R casebook, the case that you talked about Jim, there was quite a bit of -- as I could read or follow along with the hypothetical, which apparently wasn't a hypothetical, there was quite a bit of self-reporting involved in that hypothetical, correct?
A Yes.
Q And the assumption would be that the person who made this PNOS diagnosis for the purposes of the

casebook believed or had reason to believe the self-reports of that particular individual, Jim, correct?

A Well, he had been arrested multiple times for sexual assault.

Q Well, but he also self-reported about fantasies, urges, desires. The assumption would be that in the casebook those self-reports were believable and usable to the evaluator in coming to that diagnosis, correct?

A Yes.

Q And, again, you made a diagnosis of PNOS, nonconsent as to female persons -- something to that effect or paraphilic coercive disorder. You also added that identifier on the end of it, correct?

A Yes, because I think the terminology is synonymous, yes.

Q So PCD -- as I'm going to call it, PCD is synonymous with this PNOS, nonconsent diagnosis, correct?

A I think that's correct, yes.

Q And the PCD was specifically rejected by the DSM-III Board back in the '80s, correct?

A Well, it was sexual assault disorder in the DSM-III in 1980.

Q I'm sorry. '86 I believe PCD was rejected,

correct?
A Yes, that's correct.
Q And then apparently according to the article I just read from, PNOS, nonconsent or coercive paraphilic diagnosis was once again rejected by the DSM-V Board, correct?
A Yes.
MR. BELL: I don't have anything further, Your Honor.
THE COURT: Thank you, sir. Mr. Lockridge?
MR. LOCKRIDGE: Just briefly, Your Honor.
EXAMINATION
BY MR. LOCKRIDGE:
Q Not to beat a dead horse, Doctor Zinik -- has paraphilia not otherwise specified, nonconsent been ruled inadmissible in California or Washington or any other court, to your knowledge?
A Not that I know of, and this paper, this was written by Doctor Allen Frances. He's not on the -- you know, he's not on the -- not in the California Department of Mental Health. He's one of the editors of the DSM and he is a very outspoken opponent to paraphilic coercive disorder and the use and, you know, misuse of paraphilia NOS, nonconsent, very politically active in terms of promoting -- I mean, I think it would

be fair to say that he has mounted a campaign to keep that diagnosis out of the DSM.

All of his articles have this kind of tone to them. They're very politically motivated, and I'm not -- I don't -- you know, I wasn't at this meeting where this statement was made. I have seem some e-mails. We're trying to get some clarification. The California evaluators are trying to get some clarification on, you know, if there is -- I think this was kind of an offhanded comment that was made during a training by the new director, and whether it's some kind of official policy, we don't know.

I mean, I certainly would not stop diagnose -- if I found a sex offender, if you sent -- if I had to evaluate a case of a serial rapist with, you now, multiple cycles of persistence of sexual offending like I described before who commits a sexual assault, goes to jail, gets out and does it again and repeats that cycle over and over, and, you know, many of the other kind of signs and symptoms of what I believe characterize this disorder, hour you supposed to diagnose a guy like that? If he looks like he's really erotically aroused by sexually assaulting women and he even chooses to rape women when he has a consenting sexual partner available to him, what diagnostic term do

we use?

THE COURT: Is it possible that a person fitting that description could be diagnosed as paraphilia sadism?

THE WITNESS: There's a difference, Your Honor, and it's a good question, and in some ways it's kind of a question of degree, and there may a continuum actually of what -- you know, paraphilic coercive disorder or paraphilia NOS nonconsent at one end or one pole and, you know, lust, murder and extreme sexual sadism at the other end and, you know, serial rapist falls somewhere in between, but sexual sadism involves the -- what is the erotic turn-on is the suffering and the pain and the humiliation of the victim, and while it is -- now I'm going back to the description in Doctor Graney's report that Mr. King provided of, you know, that whole elaborate story of the -- the scripted form of his paraphilia.

He does -- remember he said that his biggest turn-on is to totally dominate, humiliate and subjugate women sexually, so he does -- he is aroused by the humiliation to some degree, but he made a point to describe how he -- even when he would tie them up and use bindings and the handcuffs and things like that, he didn't want it to be too tight because he didn't want to

hurt them and he didn't want blood on his car. Remember that statement?

And so he made a point of not injuring them, and so I would say and, in fact, I would rule out sadism for his diagnosis, and a couple of -- I think Doctor Bazerman also ruled out sadism or -- again, I'm forgetting exactly, but it was at least one of the other evaluators in his file considered sexual sadism and ruled it out.

And so I really -- you know, if it's true, you know, what is unique about Mr. King's case is he has made two mutually logically incompatible, you know, mutually exclusive statements. He's -- on one hand, he said, you know, I am a -- my most exciting sexual experience is kidnapping women at knifepoint, tying them up, you know, completely dominating and humiliating them sexually, making them -- exposing myself and watching them make me masturbate for hours, and I'm like a hibernating bear, and if you let me out, I'm going to wake up and I'm going to do it again. It's only a matter of time, and this time I may kill my victims, okay?

On the other hand, he said none of that's true, I made it all up, that's just a story that I concocted in order to stay in prison because I was afraid to get out and I didn't have any support, and I'm

not a sex offender, I don't have any sexual problems, I'm not going to register as a sex offender because I've never been convicted of a sexual crime.

Now, both of those statements cannot be true. And, you know, as an evaluator, I am forced to pick and choose which ones I believe, and I think clinically and I think in terms of the actuarial assessment, it is really important to err on the safe side in this case. I mean, I just find -- again, with all respect to Doctor Saleh, you know, I look at the data very differently than he does.

I think there is enough data to conclude -- to support a diagnosis, whatever terminology you want to use, that Mr. King is sexually aroused by forced sex with nonconsenting women.

THE COURT: Okay. Thank you.

MR. LOCKRIDGE: I have no further questions, Your Honor.

THE COURT: Mr. Bell?

EXAMINATION

BY MR. BELL:

Q Just briefly, Doctor Zinik. So you agree as you sit here today that you did have to pick and choose and make value judgments with regard to which statements of Mr. King you believed and which ones you didn't believe,

correct?
A I wouldn't say value judgments. I mean, I think when you have got two mutually incompatible -- logically incompatible statements, yes, you do have -- I would say I made some professional and clinical judgments and I did pick and choose, yes.
Q Okay. And would you also agree that since 1988 to the present time, there's absolutely no evidence in the record while he's been in custody of any sexual misconduct of any kind except for one incident in 1993 where he supposedly asked a female staffer to touch his penis? Would you agree with that statement?
A Yes.
MR. BELL: Nothing further, Your Honor.
THE COURT: Anything else?
MR. LOCKRIDGE: Nothing further, Your Honor.
THE COURT: Let me tell you what I'm thinking about. I'm thinking about the evidence -- the report that you had mentioned, Mr. Gray. I don't know whether the Government is seeking an opinion of Doctor Zinik regarding that. I'm wondering -- I assume we don't have that report at this time.
MR. GRAY: No, Your Honor, we don't have that at this time.
THE COURT: What I was thinking about, since

we have both Doctor Zinik and Doctor Saleh -- am I pronouncing your name correctly, Doctor Saleh?

DOCTOR SALEH: You did, actually.

THE COURT: Okay. We have both these gentlemen here now. I'm wondering whether it would be possible -- and, of course, each of these gentlemen could say whether they were being provided sufficient information to offer an opinion or whether this report, the data in that would affect their opinions in any way, but -- whether it would be possible to frame some type of a proffer, a description of what we're talking about here that can be presented since we have them here for them to hear and offer their thoughts on.

MR. GRAY: Your Honor, this was one of the -- we had considered at least from the Government's standpoint whether or not -- while Doctor Saleh was on the stand whether or not we should ask him to give an opinion based upon the hypothetical. However, we're still -- as you know, we're here in trial. We're still trying to get a full -- ascertain -- a full grasp on all of the facts. Any proffer I give right now I feel would probably be lacking the overall facts and circumstances of what took place.

THE COURT: That's fine. I'm not aware, obviously, of the extent of the information obviously

that the Government's in possession of at this time.

MR. BELL: I mean, obviously we would be concerned if we don't have a full view of what did or didn't happen. They may give an opinion that might change on one fact or two facts that we don't know about, so we would object to that.

THE COURT: Okay. Very good. Thank you, Doctor Zinik. You may step down, sir. Any further evidence, Mr. Lockridge? Mr. Gray?

MR. GRAY: Your Honor, we don't have any further evidence at this time, but we would renew our motion to have this hearing open until we get an opportunity to fully vet out this information. Once again, we're not asking this in the sense of trying to be tricky or to unnecessarily delay the schedule of any of the participants in this trial. However, we have -- information that has been related to us would have bearing upon the issues at stake in this case as to whether or not Mr. King is, in fact, a sexually dangerous person or has engaged in any sort of act within the last -- as Mr. Bell mentioned, since 1988, any acts of sexual deviancy or sexual acting out.

THE COURT: That's fine. We can address that again after we get done with the other proceeding that we may have. Other -- Mr. Bell, is there any other

evidence?

MR. BELL: Your Honor, if I can have just a moment, I'd like to talk to Doctor Saleh and make that decision as to whether or not we need to call him back.

THE COURT: We can just take our afternoon break. Why don't we err on the side of being sure you have enough time -- why don't we reconvene at 2:45?

(Whereupon off the record.)

THE COURT: Mr. Bell, we did come back a bit earlier than I had anticipated. Have you had sufficient time to speak with Doctor Saleh?

MR. BELL: I have talked to Doctor Saleh. However, Mr. King has just requested that he have a couple of minutes with me, and I have not spoken with him, so if The Court would indulge us in that --

THE COURT: Mr. Gray, you were standing. Do you have --

MR. GRAY: Yes, Your Honor. I just wanted to advise The Court that I've had a chance to get additional consult with my supervisor, Mr. Renfer, and he advised me of sufficient facts that would assist in a proffer. I understand that there will be some discussion on that point. I know that Respondent's Counsel would object to it, but we're prepared to provide a proffer if The Court should desire us to do so.

THE COURT: Have you cleared those facts with Mr. Bell?

MR. BELL: I haven't had an opportunity to share them with Mr. Bell as of yet. I can do that with him as soon as I can at the first opportunity.

THE COURT: Yes. I would like you to do that. We can always -- I mean, one solution may be to present the facts on a hypothetical basis.

MR. BELL: Your Honor, I talked to Doctor Saleh briefly about what little he did know about the situation, what potentially it could mean, and, frankly, he's very reluctant to give any sort of opinion about what may or may not have happened without having the opportunity to talk to Mr. King about it, ask his thoughts about it and that sort of thing. And Doctor Zinik may want to do the same thing.

This is not something that I think we can do in a proffer type, hypothetical type situation, because we're not talking about a hypothetical individual. We're talking about Mr. King, and we're talking about a situation -- that they allege apparently he did something, which I'm not exactly sure what it was, so it's not a hypothetical. It's an actual, apparently, situation, so I don't think a hypothetical works in that situation.

At least my expert is saying he would not be comfortable rendering an opinion with regard to that conduct without, you know, having the opportunity at least to talk to the client about it.

THE COURT: Well, let's take this one step at a time. Why don't, Mr. Gray, we take a break here to enable you to convey that information? Mr. Bell, you need some time to speak with your client. How much time do you anticipate that you need, Mr. Bell?

MR. BELL: He just said four or five minutes. I don't know how long it's going to take for us to talk --

MR. GRAY: -- I'm not adding any additional facts to what you already know. I'm just going to basically tell him what we would offer as being the hypothetical.

THE COURT: Okay. Well, let's reconvene at 2:55 p.m.

(Whereupon off the record.)

THE COURT: Mr. Bell?

MR. BELL: Your Honor, I'm going to call Doctor Saleh back to the stand briefly, but I do want to just apprise The Court of what we've talked about and just update you, and Mr. Gray can jump in if I get anything wrong.

With regard to this issue that something may or may not have happened yesterday, --

THE COURT: Yes, sir.

MR. BELL: -- what we believe is appropriate is if the Government chooses to pose a hypothetical situation to the experts and it's a hypothetical situation -- to opine as to whether or not this would affect their opinion one way or the other as to their diagnosis and so forth -- however, if The Court intends to consider that as substantive evidence, in other words, whether it actually did or did not happen, then our position would be that we would have to have a hearing to assess the credibility of the information and so on and so forth, but the good news about that is it appears we can finish with the experts on the basis of a hypothetical and then perhaps deal with the evidentiary part.

Of course, if The Court wants to hear or consider this on merits, then -- what I mean by the merits is as to whether something actually did or didn't happen, then we may have to -- I don't know if reconvene is the proper term or what have you, but have some sort of hearing on that very limited situation.

THE COURT: Okay.

MR. BELL: I'm just throwing that out.

Obviously it's up to The Court as to what we do.

THE COURT: Oh, no. That's fine. That was the reason I mentioned hypothetical. I thought with the experts here, it might be a way of not having to trouble them further with it.

MR. BELL: But at this time, I would call Doctor Saleh back to the stand.

THE COURT: Okay. Very good. Doctor Saleh, sir, let me just remind you that do remain under oath.

THE WITNESS: Yes, sir.

BY MR. BELL:

Q Doctor Saleh, there was some discussion in your original testimony, and I think Doctor Zinik talked about this hypothetical in the casebook related to this Jim individual. If you would, point out to The Court some of the issues that you think exist with regard to a diagnosis from a casebook based upon either a hypothetical or real individual and a diagnosis in this case as we sit here today with Mr. King.

A Yes. So the issue of the casebook that -- may use it for training purposes to train students, residents and so forth to help them understand sexuality -- and so that's one that the -- something completely different in a clinical setting and we see this many times. Patients may be treated without --

diagnosis, whether they may not be given a diagnosis and months may go by until they get a diagnosis, even if the sex offender therapy setting -- we have in a clinical community. So diagnosis is many times irrelevant. People are referred to sex offender therapy without a diagnosis whatsoever and they are treated, talked to about sexual issues, sexual behavior, so that's, I think -- fundamental difference.

The second thing is in -- particular case is that given what I heard earlier, the individual that's Jim has been considered or is considered to be a reliable reporter, and, again, in the clinical setting we don't go and second-guess the patient's intent, thoughts when they come to see you, volunteer. The assumption is that they're there to get help. We're not going to do a forensic assessment or anything remotely close to what we're doing here to determine if they're accurate or inaccurate with regard to what they report to us.

So here you have somebody who reports these fantasies, these thoughts, and the assumption there is and -- threshold is very low is that what is reported is indeed accurate. So that would be, I would say, the fundamental difference that we talk about in clinical setting, was it reliable -- supposedly reliable patient

and here you talk about forensic setting -- is court of law not with a patient with whom you have a therapeutic relationship, but with a respondent who is not in any therapeutic relationship with you, and so that's --

Q Again, just, again, to reiterate it, this DSM casebook is in no way a part of or included -- overall two set volume of the DSM-IV-T-R, it is a separate book that has case histories and I guess examples of things not part of DSM-IV-T-R, correct?

A Right. And, again -- equate it as a proxy of introducing a diagnosis or giving it validity. It's -- in my opinion, again, it would be misleading because it wasn't existent when we had discussions in the DSM-IV about this diagnosis -- this casebook was there.

I actually worked with Director Fred Berlin and so -- know Fred Berlin, and now after I heard Doctor Zinik -- that case, I know this patient, know about the case. And so that's something that was known to people for years, yet despite that understanding, that knowledge, the DSM-IV-T-R has -- refuted and various organizations have refuted this diagnosis, so to come now backward and say that because it's in a casebook that it gives it validity, it's, in my opinion, again, incorrect and it's a misrepresentation of what this -- are meant to be.

Q Thank you, Doctor Saleh. Now, you heard Doctor Zinik's testimony related to the fact that he -- I don't want to put words in his mouth, but he essentially had no choice but to pick and choose factual self-reports from Mr. King -- he stated that, you know, what else am I going to diagnose him with. What problems do you see with that sort of approach to -- when you're doing a forensic evaluation?

A With all due respect to Doctor Zinik, I have to say I was very surprised by -- demeanor and that question that he apparently addressed The Court. The scope of a forensic psychiatrist, psychologist or scientist is not to make up diagnoses or draw conclusions in terms of diagnosis of psychopathology. Criminal behavior is criminal behavior, and there are many types that -- people engage in criminal behavior -- which could be serial rapists going out and killing, murdering, assaulting, heroin addict who may go and rob to get drugs.

If I go and pathologize everybody who comes in because they engaged in some bad criminal behavior, if it's sexual, the heroin addict, the murderer, the intruder, then what I do is I pathologize criminal behavior, and that's not the scope and role of the scientist or the psychologist or psychiatrist. So if you

can't diagnose, if there's no basis behind the diagnosis, you don't diagnosis, there's no need to diagnose.

The other question that we were asked -- I believe even Doctor Zinik did not come up with a diagnosis -- it was look at the data and draw conclusions if you can apply them to the statutes. That's the issue in front of us, not to -- necessarily to make up a diagnosis, so why would I go and pathologize criminal behavior? That is what -- I think what I understood Doctor Zinik's testimony -- he was compelled to do and therefore choose among those statements and ended up choosing this statement Mr. King made that would allow him -- diagnosis on what basis, what scientific philosophy behind it I -- don't understand it, was --

Q Just to be clear, when you say pathologize criminal behavior, what do you mean by the term pathologize?

A Meaning that I'm trying essentially to translate criminal behavior he engaged in and call the behavior symptoms or sign of that disorder.

Again, take the example of a bank robber. He may go and rob a bank and in the context of robbing the bank he may go and kill the bank teller. I could certainly --

and there are people who do it -- come back and say well, let's understand him, understand where he's coming from, that we have to forgive him -- a certain sense because the robbing of the bank occurred in the context of a syndrome that is called bank robber syndrome in the context of being poor, so I understand it and treat him and look and approach his case differently than I would with anybody else who would engage in this behavior which is just walking to the bank robbing and killing somebody and I would just look at the behavior which is criminal. It's not a sign or symptom of a disorder and that's -- and people reach for a number of reasons and many times they reach for reasons that have nothing to do with sexual disorder or psychiatric disorder.

That's why -- I think it's where you erroneously pathologize behavior and call it sexual behavior or rape disorder, and that's where the problem is.

Q And finally, Doctor Saleh, you indicated earlier in your testimony that you acted as "gatekeeper" at times for the prosecuting attorney. Explain to The Court exactly what you meant by that term.

A Yeah. I actually asked to clarify because, again, my role is not to police -- my work and what I did, so thanks for asking, yeah. So the issue is that I am retained by the district attorney's office, this one,

actually, by the attorney's office in Worcester in getting a set of records, which can be voluminous or it can be just 50, 60 pages, and my role is to review these records and then provide the district attorney's office with an opinion to a reasonable degree of medical certainty whether or not the respondent meets sexually dangerous person definition as defined by MGL 123A.

If I say yes, the person meets the definition of a sexually dangerous person, my recommendation is that I would recommend that that person be further assessed. If I say that he does not meet the definition of a sexually dangerous person, I say that no further assessment is needed or I just conclude that in my opinion he does not meet the definition of SDP.

So I think the term gatekeeper -- I don't want that to be misinterpreted or, I mean, misconstrued as something that I'm not. I mean, I just report back to the DA's office and then the DA may follow through with my recommendation or may choose not to follow through with it.

MR. BELL: Nothing further, Your Honor.

THE COURT: Doctor Saleh, the reference you gave, this MG or something to that effect --

THE WITNESS: That's the Massachusetts -- MGL 123A.

THE COURT: Very good. Thank you, sir. Mr. Gray, any questions?

MR. GRAY: Thank you, Your Honor.

EXAMINATION

BY MR. GRAY:

Q Doctor Saleh, you mentioned rape paraphilia. Mr. King hasn't been charged with rape, has he?

A No.

MR. GRAY: Your Honor, we have no further questions on rebuttal at this time. However, we would -- for the sake of expediency, if we might be able to pose a hypothetical to Doctor Saleh at this time, we indulge The Court's favor to do so.

MR. BELL: No objection, Your Honor.

THE COURT: That's fine.

BY MR. GRAY:

Q Doctor Saleh, I'd like to pose a hypothetical to you. If hypothetically you were -- if you were to learn that Mr. King were to have had while in custody of the US Marshals within a confinement facility exposed his genitals to a female within that facility, would that cause you to change your opinion as to whether or not he's sexually dangerous or has engaged in paraphilic behavior?

A It would not change my opinion.

Q And would it change your opinion to learn that he did that -- if he did that behavior during the course of this trial?
A I wouldn't be surprised. It wouldn't change my opinion, no.
MR. GRAY: No further questions. Thank you.
THE COURT: Mr. Bell?
MR. BELL: Nothing, Your Honor.
THE COURT: Doctor Saleh, I wanted to ask you a question just to make sure that I've got these concepts straight in my mind. I know you testified on this. I just want to be clear that my understanding is correct. In your opinion, is it possible for there to be a person somewhere out there in the world who would find sexual arousal from a sexual encounter by the nonconsensual aspect of that encounter?
THE WITNESS: If you don't mind, may I just ask that -- I clearly understand, so that they would be aroused by the nonconsenting aspect of the sexual encounter?
THE COURT: Yes, sir.
THE WITNESS: If there's a person out there -- certainly possible, yes --
THE COURT: And that, as I understand it, is a separate question from whether or not that condition

should be included in the DSM --

THE WITNESS: The issue -- I'm not 100 percent sure if I understand the question, but I think I do. So hypothetically let's say that -- let's give the example we have here and say that that is a person who self-reported -- reliable and who was reporting to get aroused by the nonconsenting aspect of the sexual encounter and he's a live person and say that's, indeed, the case, so that's his sexual experience.

And, now, does this mean that if there is somebody with this condition that would equate to a diagnosis that would warrant inclusion in the DSM? The answer would be no, because I can give you an example that -- I have a patient of mine who gets sexually arroused when he drives a car and he -- now, does it mean that this experience of this one particular man I consider to be a reliable reporter -- would that warrant now inclusion in the DSM of a diagnosis? I wouldn't know even how to term it. The answer would be no, because in order to diagnose somebody or provide that diagnosis, you need to have more than just one case report. And, again, this one case report, I don't know the details of this case.

And I also have to say it depends how you elicit that information from the individual. So if I

phrase the question in a certain way, the patient may respond in a certain manner to me, yet if I ask the question in a different way, the answer to that same type of question would be different. So how much of this is suggestive to them to respond to you affirmative because I'm trying to make and support a diagnosis, That's also something that has to be determined in general.

And that's, again, where I look at differentiation between -- sexual disorder. It's many times very difficult, if not impossible to draw the conclusion that somebody is aroused to the very specific and narrow aspect of the sexual encounter which is nonconsenting aspect because there's much more going on into a sexual encounter than just nonconsenting aspect. So just to be able to say that and say there is actually something like that that I can clearly make the distinction and say that the interest is not dominating or controlling the victim but it's a nonconsenting aspect, I think it's difficult to make, and that's why in part that diagnosis has been refuted, because it's difficult, if not impossible, to differentiate between other behaviors people engage in that we would call criminal and rape and their -- pathology and disorder.

THE COURT: But even if you could isolate the

person who is aroused just to that one nonconsenting feature, my understanding is that alone -- you have one person in front of you who -- for whom that's true, that doesn't provide a sufficient basis to recognize that as a -- a condition that would apply to other people because you'd have to have evidence showing that this isn't just a one time phenomenon for this one person. You've got to -- you'd have to show that there are other human beings would have this condition, is that --

THE WITNESS: And that's, indeed, the point, to be able to determine that that experience is a valid experience that would warrant and justify diagnosis consideration in a book like the DSM. So you may have -- idiosyncratic experience like a patient that I was referring to who gets excited driving a car, but this on its own doesn't justify diagnosis because that -- goes much more into a diagnosis than one case report, and even if you looked at the research we do, you typically don't rely on case reports. They are not considered to be scientific and valid -- treatment or diagnostic decisions. It's what they are. It's case reports with all the limitations that go hand in hand with case reports.

THE COURT: I see. Let me shift back now to the hypothetical. You testified that it would not change

the opinions. Let me ask you, sir, why would that not change?

THE WITNESS: Because, again, the question before me is if Mr. King is suffering from this serious -- and agreeing that he meets the first prong, but the second prong being does he suffer from this serious mental illness, disorder or condition, and then I have establish the nexus as a result of it he's -- and he would have difficulty in refraining from violent -- sexually violent conduct or child molestation. I think the language of the statute --

THE COURT: Yes.

THE WITNESS: So if that's the language of the statute and we have this alleged incident of him having exposed himself in the middle of a trial -- and, actually, I don't know if there were other inmates or staff or whatever that may have been -- but he exposed himself to women. And let's look at it from the worst case scenario. Let's say you have him now exposing himself to other women, and we do know that he was diagnosed in the past with exhibitionism. The data available to Park Dietz and Doctor Alessi in 1976 allowed then to justify that diagnosis.

And then since 1976 or '77 -- I might be wrong by one year or two -- there was no incident of

exposing behaviors, and then you have this one single incident of exposing. Would that now change my opinion with regard to the current diagnosis of exhibitionism? Because that's really the question I think one would have to ask is does this now mean that because of this one incident in a person who has antisocial personality disorder, does that now mean that he suffers from exhibitionism, everything that I was saying and describing earlier is mistaken and erroneous? And I would certainly acknowledge yes, it could be the case, but one single episode in 35 years or 34 years of time having passed in a very circumscribed -- I mean, very -- I wouldn't want -- call it unusual -- very particular period in Mr. King's life -- which is awaiting commitment or not, that one episode would not make it the diagnosis of exhibitionism, because I would have to explain why he didn't engage in any such behavior for 35 years -- doesn't suddenly reoccur. This disorder he may have had when he was 15, 16 or 17 years of age, it doesn't suddenly return. That's one.

The second issue is hypothetically let's say if it did occur in the context of exhibitionism, was this volitional impairment that drove this behavior or was this deliberate behavior, because that's, again, important because if it would be -- I would expect

something over the last 35 years, but because of the very particular circumstance -- I mean, he's in the custody of the marshal -- exposing himself, I do know that's quite manipulative.

In terms of the behavior, he has engaged in various behaviors that ultimately were discounted and disregarded as being -- function of disorder. At least I would conclude that this is probably deliberate behavior not occurring in the context of exhibitionism, but even if I take now one further stage -- and say let me operate under the assumption that that was the first sign of exhibitionism that was dormant for 35 years, does this now mean that this exhibitionism satisfies the statutory definition of a sexually dangerous person? Based on what I know, it wouldn't, because one leg of data in all these years -- and I don't -- at least in Massachusetts, we would not consider exhibitionism as being sexually violent conduct, and so I don't think that I could make that argument.

And even when I earlier said that I agreed with the first prong, my agreement with the first prong is not because of what he did as a 15 year old exposing himself, but what he did two years or 18 or 15 months later when he fondled a victim's breast. That was the basis of me saying yes, that's why he meets that first

prong.

So given, again, the totality of all information in front of me -- and I would say even if this happened, I don't think -- at least I wouldn't be able to say that that is now a person who is a sexually dangerous person as defined by this statute.

THE COURT: Okay. Very good, sir. Thank you. Mr. Bell?

MR. BELL: Nothing further, Your Honor.

THE COURT: Mr. Gray?

MR. GRAY: Nothing further, Your Honor.

THE COURT: Very good. Doctor Saleh, you may step down. Thank you. I assume that concludes the evidence for the Respondent?

MR. BELL: That's correct, Your Honor.

THE COURT: Mr. Lockridge?

MR. LOCKRIDGE: Your Honor, we'd just like to briefly pose the same hypothetical to Doctor Zinik.

THE COURT: That will be fine. Let me remind you that you remain under oath.

THE WITNESS: Yes, Your Honor.

EXAMINATION

BY MR. LOCKRIDGE:

Q Doctor Zinik, do you recall the hypothetical that was posed to Doctor Saleh?

A Would you repeat it again, please?
Q Hypothetically speaking, Doctor Zinik, if you were to learn that Mr. King were to have while in the custody of the US Marshals in a confinement facility -- have exposed his genitals to a female within that facility, would that change or affect your opinion with regard to your diagnosis in this case?
A Well, my answer would be that it would support my opinion. If it were true that Mr. King sexually exposed himself to a female, say, hypothetically yesterday in the county jail during his civil commitment trial, I would find this very compelling evidence for a total breakdown in sexual impulse control.

Now of all times to be doing that kind of behavior would signal to me that something has triggered him, that he -- you know, something is stimulating him. Perhaps it's all the discussion here at the trial about his history. You know, if it happened yesterday after he left court -- I know Doctor Graney was a female psychologist -- a female expert was on the stand.

I am reminded of the fact that the other incident that occurred in 1993 happened within the context -- as we've said before, he was discussing this sexual disorder with a female therapist and he was talking about -- you know, if you read the infraction

report, the female therapist -- this was being recorded and they were discussing his history of exposing himself and asking women to touch his penis. He got emotional. He broke down and started crying. He asked for the tape to be turned off, and that's when he asked the therapist if he could expose himself and if she would touch his penis. So there was something about the context of the discussion it appears if -- if you just look at the sequence of events that contributed to him acting out in that sexual way. I consider this very compelling evidence. I think it's -- it is also what we -- it's a form of what we call sexual preoccupation. I mean, obviously he must have been preoccupied with sexual impulses and thoughts.

I was surprised to hear Doctor Saleh say that he could look at this as -- I think he said deliberate behavior rather than an act of exhibitionism. I mean, I don't see any other way to interpret it other than an act of sexual exposure. I think that this is a dynamic risk factor that is -- there's empirical evidence that sexual preoccupation, which this would be a form of, you know, acting in an inappropriate sexual manner in a legal context is associated with increased risk of sexually reoffending, and I would be concerned that if he's doing this now, now of all times within the

structured setting of the jail, what might he do when he gets out?

And the fact that he -- the fact that -- as we've already said, at least as I've tried to communicate and I think Doctor Graney agreed with me that -- I think this is evidence of his exhibitionism. I think it does support the diagnosis of exhibitionism, and we -- I've said how -- and Doctor Graney said as well that there is in a sense a merging or an intertwining of his exhibitionism and his coercive sexual paraphilia or whatever terminology you want to use to describe it. These things are combined in a sense for him, and so I'm very concerned that if he's starting to expose himself again and he were released to the community, he would be at high risk to expose himself and to commit these same kind of sexual assaults that he has in the past that he has described that involves sexual exposure and that, you know, he has been reporting since the mid 1970s.

THE WITNESS: So I look at this very differently, Your Honor.

MR. LOCKRIDGE: Nothing further, Your Honor.

THE COURT: Mr. Bell?

EXAMINATION

BY MR. BELL:

Q Doctor Zinik, if hypothetically this incident occurred, would you agree that it would be the first incident of exposure that's documented anywhere other than through Mr. King's own words since the 1970s or -- well, maybe 1978 was the last incident where there's evidence outside of his own statements where he exposed himself. Would you agree with that statement if it occurred?
A Well, you know, we've got the '93 incident. He didn't expose himself, but he talked about it. He asked if he could do it. And then prior to that was the second sexual offense that he was arrested for at age 17 where he exposed himself to the female victim in the car and forced 'em to touch his penis.
Q Right. So you're talking about '78 to now?
A I think that one was actually '75.
Q '75 to now, this would be the only -- if it occurred, this would be the only incident other than that one back in '75 and then the one incident in '93 where he asked the staffer to touch his penis?
A That we know of, yes.
Q Okay. And you still agree as you testified on Monday and actually Doctor Graney testified yesterday that without a diagnosis of PNOS, nonconsent, you would opine that Mr. King is not a sexually dangerous person

under the act?
A Yes.
MR. BELL: Nothing further, Your Honor.
THE COURT: Redirect, Mr. Lockridge?
MR. LOCKRIDGE: Nothing further, Your Honor.
THE COURT: Very good. Thank you, Doctor Zinik.
THE WITNESS: Thank you, Your Honor.
MR. BELL: -- nothing further from the Respondent by way of evidence.
MR. BELL: Nothing further at this time, Your Honor.
THE COURT: Very good. Thank you. Do Counsel wish an opportunity to make closing arguments?
MR. GRAY: Yes, Your Honor, briefly. At this time, we'd like to ask if we may excuse Doctor Zinik from the courtroom so that he can get his travel back --
THE COURT: I assume there's no objections.
MR. BELL: No, Your Honor. In fact, I'm scheduled to take Doctor Saleh back, but that's assuming I get finished here in time to do that. But, no, that's fine.
THE COURT: Okay.
MR. GRAY: Thank you, Your Honor.
THE COURT: What's your time frame, Mr. Bell?

MR. BELL: -- quarter 'til five, so I don't -- I think we should be okay.

THE COURT: I don't anticipate arguments taking that long.

MR. GRAY: No, Your Honor, certainly not from the Government.

Your Honor, the issue before us is whether or not Mr. King meets the criteria under 4248, and in doing that, there's been a lot of discussion about whether or not Mr. King's a liar, but ultimately that's not the issue. The issue really comes down to whether or not he's engaged or attempted to engage in sexually violent conduct or child molestation. And, once again, the statute doesn't require that that's a conviction -- just means that he's engaged in or attempted to engage in that sexually violent conduct, that the Respondent suffers from a serious mental illness, abnormality or disability and as a result of that abnormality or disorder, he's going to have serious difficulty refraining from sexual violence or child molestation if he's released.

But, Your Honor, we would like to just -- once again just remind The Court that what's really at stake here when we take a look at the statute is whether or not Mr. King can be subjected to court ordered

treatment. It's very much like 4246, and the determination as to whether or not The Court can order Mr. King to undergo this treatment, we have to make a determination as to whether or not there's a -- he's going to have serious difficulties from refraining from acts of sexual violence as a result of a serious mental illness, abnormality or disorder.

Now, there's been a lot of evidence that's been presented to The Court with regard to his past conduct, and a little bit of that evidence when it comes to his past conduct is relevant in one of the issues that's been postured within this -- over the course of this hearing of whether or not you can believe the self-reports of Mr. King.

I anticipate that the Respondent will say that if you take Mr. King's self-reports out of the picture, you have a person who hasn't acted on any behavior since 1993 where he solicited an intern in Federal prison to touch his penis, and prior to that, 1978. However, if you take a look and do as both Doctor Saleh and Doctor Zinik suggest you do, look at the entire record in context, it's very clear that what we have here is a person who has a serious mental disorder in the sense that this is a person who becomes sexually aroused when he is placing women into a point of

subjugation, fear and binding. That is his sexual disorder, and he finds great gratification in that.

Now, we get that from a lot of his statements, but his statements are not only corroborated by past history -- because if we take a look at the diagnosis of those in the Phipps Clinic in 1976, they said yes, he is a person who isn't honest, and they recognize that. And if you take a look at Government Exhibit Number Nine, it will tell you that they recognize that he is not an honest person. They did, as Doctor Saleh and Doctor Zinik did -- took a step back and fairly evaluated the information and made a determination based on the entire record as to whether or not his statements under these conditions could actually be believed.

And they took a statement seriously enough to include as a part of his record to say that this is a person who has thoughts of rape, thoughts of binding women and thoughts of subjugating women, and that's as early as 1976. As we start to take a look at his conduct in 1983 and in 1988 when he's engaging in the abduction crimes, the most -- 1983 abduction crime, we see a pattern that emerged.

He talked about while he was serving time in prison -- his desire to engage in binding of women, how

he liked to be able to force women into this sort of position. He gets out of jail, and what do we see in 1983? In 1983, he's engaging in that sort of conduct by taking a woman who is walking out of a bar who is vulnerable, pushing her into a car, and then when he's later arrested -- and as you heard the details from Mr. King, Mr. King detailed in great detail how he was arrested driving northbound on Wisconsin Avenue and got pulled over in Brandywine when the cops found these items in his car, the rope that was secured to a seat belt holster, the knife which wasn't located in the car, but Mr. King admitted that there was a knife and so did the victim in her statement -- said that there was a knife involved in that offense -- the handcuffs which were found on his person, the air pistol which was the crime that he pled guilty to in terms of carrying a deadly weapon, but most importantly are the things that he had with that entire, as he termed it, rape kit which was there to help further his overall goals.

This is something that we need to place in context of the entire history of Mr. King. What was his intent? Well, we know what his intent was based on his statements to psychiatrists outside of the Bureau of Prisons and within the Bureau of Prisons. He enjoys placing women -- to a position of subjugation. This is

what sexually stimulates him.

Now, one of the things that we do when we look at that, we look at that to determine whether or not he suffers from a serious mental illness, abnormality or disorder. Doctor Zinik, Doctor Graney, Doctor Bazerman all took a look at this context of behavior and determined that even though he's a liar, you've got to take a look at his lies and actually compare them to evidence within the records, determine whether or not there's some things you can believe.

In fact, not only did Doctor Zinik do it, Doctor Bazerman do it, Doctor Graney do it, but by the testimony of Doctor Saleh is that he did it as well, and that by doing that, what we have is Doctor Zinik, Doctor Graney, Doctor Bazerman all coming in with the diagnosis that he was suffering from paraphilia NOS. The fact that his mental disorder is one that leads him to find sexual gratification, euphoria, joy from binding women and engaging in that sort of conduct, that is his illness.

How do we know he will have serious difficulty from refraining from doing that in the future? Let's take a look at the period of time that elapsed between his confinement based on the 1983 offense and the 1988 offense, six month gap took place that -- where he engaged in, once again, the same type of behavior,

abduction of a woman, forcing her into a car. His history is replete with this sort of behavior.

Why hasn't he engaged in this sort of behavior while he's been in the Bureau of Prisons? Well, one thing is going to be that his conduct involves women that he specifically identified he specifically targets as being weak, those who are going to be more vulnerable and ones that he can basically take advantage of. He's not going to find that in the Bureau of Prisons except for the one person he did find, the green new intern that happened to be treating him when he went over to her, said let's stop the tape and said you want to touch my penis. He hasn't had a whole lot of opportunity within the Bureau of Prisons to demonstrate his overall proclivities.

However, he has told Doctor Graney and Doctor Bazerman that he enjoyed engaging in that sort of behavior and detailed to them his overall desire for this sort of thing. He told them he was like a hibernating bear. He told them these are fantasies that he had. He detailed how he likes to find -- the types of women, not Black, not foreign, because, you know, they are the easiest ones to try to take advantage of, how he would identify and track his victims like -- he even told you how he would do that. All these things put

together in the context of what we can believe from Mr. King is that we can believe that his paraphilia -- his actions over the course of his lifetime indicate that it's real.

The real question and I think the issue really coming down before all of us, the question that we all have in the back of our mind is why in the world would somebody say, you know what, I really want to be civilly committed, because ultimately that is what Mr. King said he did. He wrote a letter, a series of letters -- 30 days he was writing letters asking why haven't I been committed, I want to be committed. I talked to Bazerman, how long is it going to be before you guys make a decision? He was asking these questions.

Doctor Saleh's going to tell you that he's asking these questions for ulterior motives. You know what? Doctor Zinik may tell you that it was for ulterior motive, he's lying in order to gain something, but one thing that's consistent where all these lies -- that he'll lie until he's pushed into a corner, and when he's pushed into a corner, that's when he admits the truth. That's one consistent thing that we have about Mr. King. And what corner was Mr. King pushed into? Into the corner of civil commitment.

If you take a look at Doctor Saleh's report

at page 14, he talks about an interview in 2009 where Mr. King talked to Dianna Repiska, (phonetic) and Doctor Repiska was told about this hibernating bear thing. This is what Doctor Saleh put in his report. After the interview, this writer, Doctor Repiska spent some time processing what had transpired, and his reaction -- Mr. King's reaction to the possibility he may be referred for certification, she had to ponder on this. She was confused by this. She knew he was a liar. She had to reflect on why in the world is somebody doing this, because this just doesn't meet the pattern.

And then she comes to the conclusion he did not present any acute stress and denied any major concerns at this time. And I'm reading from the indented paragraph on page 14 of Doctor Saleh's report. It's Respondent's Exhibit Number One. Inmate King felt fairly sure that he would, in all caps, be certified and was willing to accept his part -- accept this as part of his fate. On multiple occasions, he stated he would do whatever is necessary in order to not hurt anyone in the future.

What we have here is a person that decided that they were going to try to get ahead of the curve. What was his gain in asking to be committed earlier? He recognized this. He recognized his past. He knew what he

had said to the psychologists. He knew that the chance of him being certified were very high, so what does he decide to do? He does what he always does, which is when he's in a corner, he decides to do what he can to help himself out, so he decides he's going to ask for commitment in order to get a head start on -- to show that he can be a productive member. Now, how do we know that that was his motivation as opposed to --

THE COURT: Mr. Gray, let me just ask. I think his testimony was not when he's pushed into a corner that he tells the truth. I mean, in several instances he spoke at length about how he would get behind in drug payments or work off bills for elicit drugs at prison, so by his own statement -- fabricate a story, escape story was one, I think multiple personality story may have been one, and in one instance, he felt threatened by the -- I think he described it as a Hispanic gang at one prison, or he was worried. I took that to mean he was worried for his personal safety. His response to that wasn't to tell the truth. It was -- by his statement, it was to tell a lie.

MR. GRAY: I completely agree, Your Honor. What I'm talking about, his -- his propensity of lying until he gets put into a corner, that's the statement that was made about him in Exhibit Number Nine when he

was at Phipps Hospital, and that's the statement that was made not only by him, but by his mother, he's going to lie until he gets put into a corner. But how do we know that -- and I hear what you're saying, Your Honor, and in order to determine whether or not he's telling the truth or a lie as to his overall motivation, I want to get into civil commitment because I've heard about Coalinga State Hospital and I heard that it's great conditions and I had heard it's really nice and I did all the research on it. All we have to do is do what all the doctors and everybody in this case should do, look at the actual tangible evidence to determine whether or not what he's saying is true.

Mr. King testified that Exhibit Number 21 was the document that he looked at and he researched prior to him being -- prior to him sending off the letter saying I want to get out of here, I'm revoking everything I've said, but if we take a look at the bottom of Exhibit 21, it tells us when that document was printed out. It was October, 2010.

Now, how else do we know that Mr. King was just lying about revoking his status for some other reason? Well, let's take a good look at what he told us on the stand. He said I knew within 30 days of being in the Maryland house that I didn't want to be here because

I knew it was a prison, yet it was 90 days after that that he wrote his first letter recounting -- April is when he sent the letter off recounting what he said to Doctor Graney. However, he said he had been there for 30 days and knew that it wasn't where he wanted to be.

It's not as if he didn't know he couldn't write letters. When he was trying to get certified, he wrote letters almost every 30 days to the warden, to the CRP, to his unit manager, but when he finds out that he's going to be in Maryland House and he's going to be under, his words, prison conditions, he doesn't write a letter immediately. He doesn't recant immediately. It isn't for months that he decides he's going to recant. It's when we look at all of his actions in context, that is what gives us the indication as to whether or not we can believe certain things about him.

Now, when it comes down to the real issue of whether or not he's engaging in -- whether or not he's suffering from a serious mental disorder or illness or abnormality, we've seen the testimony and we've heard the testimony and we've seen the report that he exhibits the characteristics of a person suffering from paraphilia NOS. Do we know 100 percent for sure that he's going to engage in acts of misconduct or acts of sexual violence if he's released? We don't know that for

sure. Nobody will be able to tell you that. Doctor Zinik told you very clearly that actuarials don't tell you that sort of stuff. It's not appropriate to even use 'em in that way.

The question we have to ask ourselves is is he going to have serious difficulty refraining from engaging in that conduct if he's released. His past history indicates to us that he will have serious difficulty refraining. The fact that he has not engaged in any treatment or therapy while he's been in the Bureau of Prisons indicates that he will have serious difficulty if released.

But most importantly, I think, are his own words where he said that he is not a sexual offender, and more importantly, what he told Doctor Saleh which was he's fine. All of this in context gives us a clear indication to let us know whether or not we can weigh and determine whether by clear and convincing evidence we feel he's going to have serious difficulty refraining from engaging in acts of sexual violence or child molestation.

Your Honor, with all this evidence that we put before you, this question -- and we feel that all of this evidence viewed in context appropriately shows that Mr. King has engaged in acts of sexual violence or child

molestation in the past, he has a serious mental abnormality, illness and disorder, either an antisocial personality disorder as diagnosed by Doctor Saleh, but -- paraphilia NOS as diagnosed by Doctor Bazerman, Doctor Graney and Doctor Zinik and that he will have serious difficulty refraining from engaging in acts of sexual violence as a result of his paraphilia NOS and/or his antisocial personality disorder.

Thank you, Your Honor.

THE COURT: Thank you, sir. Mr. Bell?

MR. BELL: Thank you, Your Honor. Your Honor, first I just want to talk briefly about the facts related to the offenses that Mr. King has been charged and the circumstances surrounding those facts and the information about those circumstances and where it comes from.

It's clear that he was found guilty of exposing himself at the age of 15, convicted of indecent exposure, placed on probation. There is objective evidence of that in the record, police reports, conviction records and so forth. October, 1975, again he's convicted of abducting a 19 year old female, placed on probation, clear evidence in the record of fondling, clear evidence in the record -- well, there's evidence in the record -- it goes both ways, but there may have

been an exposure situation. It may have been a touching of his penis. That's 1975, age 17. So we would concede as Doctor Saleh conceded on the stand or testified that yes, at some time in the past Mr. King has been involved in serious sexual conduct.

Prong one of the test is met, but you have to draw a line of demarcation in this case in 1975 and thereafter, because in every instance thereafter when he's charged with a crime, there's no clear objective evidence that it was sexually motivated and certainly more specifically motivated by the nonconsent coercive aspect of sexual arousal.

At age 19, he was charged and found guilty or pled guilty to attempted abduction -- no evidence in the record really of any kind about that offense other than his self-reporting that it was sexually motivated. November 23, 1983, simple assault, CDW, carrying a deadly weapon, age 25. If you listen to the Government's part of the spin on the evidence, there may be some evidence that there were tools for rape in the vehicle or on his person. Well, he also was a tree climber, so there was also tools for tree climbing in the vehicle, but there's no statements other than Mr. King that indicate in any way that that offense was sexually motivated. Even if it was sexually motivated, it

occurred when he was 19 years of age, and he's now 53. And, again, further, there's no evidence even if it was sexually motivated that it was motivated by this coercive intense arousal by the coercive aspect of the offense other than Mr. King's word certainly.

And, finally, the offense that he's been serving time on since February of 1988, armed kidnapping, age 29, frankly, Your Honor, the objective evidence would indicate that this is not a sexually motivated offense. You heard Doctor Zinik himself testify that one of the reasons he found the offense to be sexually motivated is there was no mention of money, no talk of cash, no you have money, that sort of thing. Well, in this particular case, clearly the record, the objective record that nobody can argue with is that he did ask her if she had money, did she have a lot of money, and his only testimony was that it was -- motivation for the crime was to rob her.

All of the other reports of sexual offenses come solely from Daniel King, a man who's been diagnosed time and again as a chronic liar, manipulator, and even Doctor Zinik, the Government's witness in his report stated he is a pathological liar, he was unreliable. And, quite frankly, Your Honor, as he sat on the stand on Tuesday and testified, I can't tell you whether he

was telling the truth or not. I don't know. I know he testified. I don't know if he was telling the truth or not. No one can tell that about this individual. I hate to say that about my client, but I think it's the truth.

The objective facts related to Mr. King's sexual conduct, however, since he's been incarcerated can be documented and it is objective. Probably his daily life was more monitored for the years that he was in prison from 1988 to now than certainly it ever was before that and more monitored than any individual who lives out in the world. These guys, they get up at a certain time. They eat at a certain time. They go to bed at a certain time. They have a job at a certain time. You know, there is no room for things to happen that would not be reported in the record.

When you look at that, from 1988 to the present time, there are absolutely no sex offenses, infractions, write-ups of any kind related to male or female staffers, related to male or female inmates other than the one incident in 1993 where it's alleged that he asked a female staffer to touch his penis. He denies that. I don't know if he's telling the truth or not, but that's the only incident objective in the record in 24 -- almost 24 years period of time.

He's an admitted bisexual who has said that

he's had numerous homosexual partners while in the Bureau of Prisons, and, again, even though his access to females was very limited in the Bureau of Prisons, his access to other male inmates was not. And you heard Doctor Saleh testify that it wouldn't necessarily be -- sexual orientation wouldn't necessarily play into the paraphilia if it exists, and there are no sex offenses, infractions, write-ups related to any males -- staffers or inmates again for a period of 23 years.

The Government doctors would say and did say that he's in a penal setting. He's in the Bureau of Prisons, he is controlled, his conduct is controlled. However, his conduct may have been controlled, but it certainly did not keep him from getting in trouble. He got in trouble a lot. Dirty urine tests, talking back, insubordination to staff members, all of these things that are in the record clearly show that he didn't have a problem going to the SHU, he didn't have a problem getting in trouble, and of all of the infractions and incidents that he had, again, the only one of a sexual nature occurred in 1993, and, again that involved no touching of any kind. It was simply a proposition. He has manipulated the mental health system to -- in whatever maybe skewed way, he thinks it's helping him since he was a child essentially.

You know, you heard him testify that he learned early on that if he was sick, things would go easier for him. That may not be true, probably isn't true, but in his mind, it was. He feigned, malingered at least 12 different diagnoses, at least 12. There are probably more -- that none of the doctors that you heard from in this case, in this trial found. He faked an escape attempt and then turned himself in so he would get caught, so he would get shipped to another facility. He's been in nine facilities in his time with the Bureau of Prisons. He's used the system, the mental health system to help him do his time. You heard him say it.

The precertification process, his testimony that he wanted -- he had nowhere to go, I think you can tell from his testimony he's not a dumb person. He's relatively intelligent. He's been institutionalized for a long time. He knows how the system works, and in the past he's been successful in manipulating the system, and I believe in this case he felt like he was going to be successful in manipulating again, and, unfortunately, his idea of what he was going to manipulate into was wrong. And he did an excellent job of laying a foundation through his own words to get him precertified as a sexually dangerous person.

The bottom line is -- well, and I think it's

important to note to The Court Doctor Graney's testimony that only -- I think she had done 14 or 16 evaluations, precertification evaluations, and he was only one of three inmates that were willing to talk to her. I think that's important why was he was willing to talk to her. He didn't have to. He wanted to, and he told her what he thought would help him get in because he thought it was going to be a place he wanted to be, and then he realized it wasn't where he wanted to be.

When you take it in sum, you have an incident exposure case in 1974, objective evidence. You have a fondling and a possible exposure in 1975. You have an incident with a -- there were tools found, ropes and so forth, air pistol, handcuffs found in his vehicle in 1983, and you have one sexual proposal in 1993 that did not involve any contact or touching of any kind. And other than that, you have got his word over and over and over again, but they're not consistent. He says he has this problem and he's got blackouts and multiple personalities, and now, by the way, I have sexual problems, and there's just no consistency what with he has said over the years.

And I think Doctor Saleh's testimony was very profound in that you have to look at all of these statements in context. You can't pick and choose. What

helps you -- helps you get to the goal line -- the goal line being civil commitment or a diagnosis that gets you to civil commitment. You've got to look at it all and take it and weigh it looking at it in the context of making a diagnosis, not the diagnosis.

Both Government experts agreed when they testified on Monday and Tuesday, and then Doctor Zinik agreed today again without a diagnosis of paraphilia NOS, nonconsent, Mr. King is not a sexually dangerous person under the act in their opinion. Doctor Saleh did not diagnose him with PNOS, nonconsent, so if The Court finds that he did not suffer from this paraphilic disorder, we contend that he cannot be a sexually dangerous person under the evidence before The Court today or in this trial.

Paraphilia NOS, nonconsent -- paraphilia, the individual must present with recurrent, intense sexually arousing fantasies, urges or behaviors generally involving nonhuman objects, suffering or humiliation of one's self or one's partner, children or other nonconsenting persons over a period of more than six months, and there must be impairment.

The specific -- I'm not going to call it diagnosis, but the specific condition or label of paraphilia NOS, nonconsent, the individual must

present -- and it must be shown that his arousal in the nonconsent aspect of the interaction with the victim, the coercion, it must be recurrent and intense.

Any rape is not a paraphilia. Any sexual offense is not a paraphilia. Any attempted sexual offense is not a paraphilia. It's a very specific finding that a doctor must find to make that diagnosis. And with regard to that diagnosis, you heard Doctor Saleh testify it is a fictitious diagnosis, ad hoc, it's not in the DSM-III, it's not in the DSM-IV, it's not in the DSM-IV-T-R, it has been specifically rejected in some form or another, whether it be the PCD or paraphilia nonconsent -- I mean paraphilia not otherwise specified, nonconsent over and over and over again by the APA Boards that approves the diagnoses that go in this manual that control or should control the psychologists who make diagnoses when they're treating people.

You heard Doctor Saleh, Doctor Zinik and Doctor Graney all agree that there's a difference between a clinical setting and a setting in a court of law, that the standard is higher and it must be, because we're looking at taking away this man's liberties. If The Court finds that he's a sexually dangerous person, he doesn't get out.

And when the Government says that it is only court ordered treatment, well, let me tell you about that, Your Honor. What it means -- that once he becomes a sexually dangerous person, the burden now shifts and from now on into perpetuity, he's got to prove that he should get out and the burden shifts to him, and that's a big difference. So it's a lot more than just court ordered treatment.

THE COURT: It's much more, I agree, because court ordered treatment can be imposed through a condition of supervised release, and we're talking about commitment here, and I think they are different issues entirely.

MR. BELL: I agree, Your Honor, and I think you saw from the testimony today through Doctor Zinik that this diagnosis of paraphilia NOS, nonconsent is being called into question. In California, the state where he's from, by a group that he does work for, I mean, it is a debate. He admitted it. Doctor Graney admitted it and Doctor Saleh said it. It is a debate and it's been debated and debated and debated for years, and it's not included in the DSM-IV-T-R and it's been rejected by the DSM-V.

Doctor Saleh found that there's no diagnosis of PNOS, nonconsent. Doctor Zinik stated twice that Mr.

King cannot be a sexually dangerous person without a diagnosis of PNOS, nonconsent. Doctor Graney also stated that she agreed with Doctor Zinik, that without a diagnosis of paraphilia not otherwise specified, nonconsent, he cannot be a sexually dangerous person under the act. There's no such diagnosis, but even if there was or is or is a condition, there may be one person in 100,000 people -- suffer from.

In this particular case, the Government has not proven by clear and convincing evidence -- and I do want to just briefly talk about the standard of proof. As The Court's aware, it is an intermediate standard of proof like somewhere between the preponderance of the evidence, more likely than not and proof beyond a reasonable doubt.

The Fourth Circuit case, which is the seminal case and, frankly, about the only one I can find dealing with clear and convincing evidence, states as follows. In other words, The Court must be convinced by evidence of such weight that it produces in the mind of the trier of fact a firm belief or conviction without hesitancy as to the truth of the allegations sought to be established.

In the incident case, Your Honor, when you look at the -- of inconsistencies and the evidence of

the spurious nature of this paraphilia not otherwise specified, nonconsent diagnosis and the high burden placed on the Government under the clear and convincing standard, we contend that The Court must find that the Government has failed to carry its burden of proof in this case in establishing that Daniel King is a sexually dangerous person under the act.

Thank you.

THE COURT: Thank you, sir. Why don't we talk just a minute about the matter that was the subject of the hypothetical? It seems to me one course would be to have the report on that incident filed in the court, then have -- then we'd all see what the specifics of what the allegations are, at least as reported by the deputy, provide Counsel an opportunity to confer and possibly even to come up with a proposal for any further proceedings.

As I sit here now, I don't know, frankly, whether that report is relevant. I don't know that yet without seeing it, and I don't know that Counsel is able at this point without seeing it to know the significance it has, whether or not we need to take further evidence beyond it, whether the report itself should even be admitted into the record.

I'm not suggesting that it be filed. I'm not

stating it should be a direct part of the record of this commitment. I'm not suggesting that. Whatever we do though, I think we need to do it expeditiously to keep this matter moving along. So I don't envision elaborate proceedings with respect to this development.

Mr. Gray, would a week be sufficient time for the Government to obtain and file this report?

MR. GRAY: Your Honor, it's our understanding that the deputy who filed the report, she is visiting her -- she's off duty today. She's working with her mother who apparently is ill, so we've made efforts to see what we can do about getting that as quickly as we can. A week should -- looks like that should work for us, Your Honor.

THE COURT: I'll direct that that report be filed within one week from today.

MR. GRAY: Your Honor, should we file a notice of receipt and then provide it to the other side as opposed to filing the actual report, or I guess --

THE COURT: Well, it may contain --

MR. BELL: Yeah. I would request that it not be -- at least the document itself at this point in time not be public record, but it -- file a notice and then we -- The Court can see it, we can see it and then maybe we can decide how we want to handle it or with The

Court's help how we want to handle it. I would prefer that it not be filed, the report itself not be filed.

MR. GRAY: Your Honor, I'm sorry. It looked like you were about to say something. I apologize.

THE COURT: No.

MR. GRAY: But if we were to file a notice and then within four days after that propose a course of conclusion with regard to that, within four days after receipt --

THE COURT: Well, that works. We can do that, have you all get some kind of status report, or we could have some kind of telephone conference, or we could do both, frankly.

MR. BELL: That would be fine.

THE COURT: Is four days sufficient? That would be -- we get specific about dates, today's the 19th. A week from today would be the 26th. Of course, it may not take a week.

MR. GRAY: Your Honor, the reason I proposed four days is I was just trying to make sure, because it is Wednesday -- making sure it doesn't fall on a Saturday.

THE COURT: That's fine. We can revert to the old -- format, and it's now been removed from the Federal rules. We could say three business days after

the Government --

MR. BELL: And, Your Honor, if we get it today or tomorrow, as soon as they get it and they can send it to me, we can cut this shorter if we can, obviously.

THE COURT: That's fine. You can always do things earlier, but these would be outside limits, and I direct that it be served either by e-mail or telephone fax so that we don't have to worry that it's not going to trigger an additional three days for mailing or circulation would -- otherwise allowed under Rule Six.

So within three days, business days after service, I guess I'll look for the parties to file a proposed resolution, assuming you can reach it. If you have a different position than that statement of resolution or proposal, I'll address that as well and then we'll take it from there. I would like to receive a copy of this report to look at.

MR. BELL: No. That's -- that's -- I didn't mean to object --

THE COURT: No, no, not at all --

MR. BELL: I didn't want to file, you know, where -- need to look it up.

THE COURT: I understand. I'm wondering whether the document, the report itself could be filed under seal, but the notice of filing would be filed

publicly so the public would be on notice of that. There was a police report that had been filed.

MR. GRAY: We should be able to do it under seal, Your Honor.

THE COURT: Okay. You can always work with the clerk's office on the nuances of --

MR. GRAY: Your Honor, it would help us greatly if you were to submit an order to us -- in an order saying that it be filed under seal. That would --

THE COURT: Very good.

MR. GRAY: -- all that --

THE COURT: Very good. We'll take care of that. Mr. Bell, did you have any desire to submit supplemental proposed findings? I'm not necessarily asking for them. I just wanted to inquire of you. You've submitted very extensive ones. Both sides have.

MR. BELL: Based on the evidence, Your Honor, I would at least like to have the time to have the opportunity to submit -- without having 'em -- my other ones in front of me here and reviewing 'em, I think I would like to have that opportunity. Now, I may decide not to, but --

THE COURT: That's fine. Well, why don't you wrap that issue into the status report proposal document that we have been talking about? And obviously --

provide both sides that opportunity to express their interest in it, and I would allow the parties to at least propose a deadline for submission of them, keeping in mind that we do need to keep this case progressing.

MR. BELL: Your Honor, the only possible problem with that, if we get that document from him tomorrow when we get three business days --

THE COURT: Oh. Don't misunderstand me. I wasn't saying that supplemental proposed findings and conclusions would be due by then, simply an indication of --

MR. BELL: Sort of a time frame?

THE COURT: Yeah. Whether the parties wish to do that, and, if so, what was their proposed time frame.

MR. LOCKRIDGE: I can tell you we definitely want to do that, Your Honor.

THE COURT: Okay.

MR. BELL: And I would -- probably would, too, but I just don't want to say definitively without looking at it.

THE COURT: No. That's fine. Now, if you want to include transcript citations, which you may well if you're going to do supplemental findings, I would take that into account with your -- your proposal. You may want to also speak with the court reporter about the

acquisition of the transcript. The Court obviously is going to require a transcript of this proceeding.

Very good. Is there anything else we can accomplish today, Mr. Gray?

MR. GRAY: Your Honor, one more matter of housekeeping, I've just been informed by the Marshals office that R&D is closed, so they would like to house Mr. King overnight at Wake County and -- before transporting him back, and we request that there be an order from The Court doing that.

THE COURT: What is closed now?

MR. GRAY: R&D, the prison, Your Honor.

THE COURT: Oh, I see -- inmates. Well, I think that the transport of Mr. King is in the good hands of the United States Marshals Service.

MR. BELL: Well, Your Honor, I would just like to make The Court aware Mr. King has real reservations about going back to Wake County simply because of the allegations that have been made about what may or may not have happened yesterday. He indicated to me that he does not want to go back there.

Now, I don't know about whether they can send him back to Butner, but I don't know if the marshals could accommodate him in another facility or -- I don't know, but he has expressed a real desire not to be sent

back to Wake County.

MR. KING: Excuse me, Your Honor.

THE COURT: I don't need to hear from Mr. King. You may sit down, sir. I think issues like this are probably in the -- the United States Marshals Service, I'll defer to their judgment with respect to the transport of Mr. King.

MR. GRAY: Thank you, Your Honor.

THE COURT: Anything further?

MR. LOCKRIDGE: No, Your Honor. Thank you.

THE COURT: Mr. Bell?

MR. BELL: No, Your Honor.

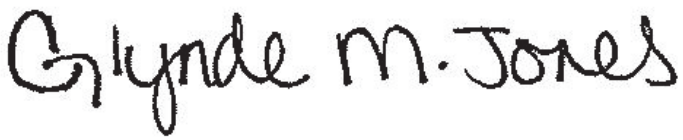
THE COURT: Very good. Gentlemen, I do want to compliment counsel for both sides on their level of preparation for this hearing. The Court did appreciate it. Very good. We'll be in recess.

WHEREUPON, the hearing was concluded at 4:37 p.m.

CERTIFICATE

I, Glynde M. Jones, Notary Public in and for the State of North Carolina, do hereby certify that the foregoing transcript of proceedings taken in the United States District Court is a true and accurate transcription of the shorthand notes of the proceedings taken by me in machine shorthand and transcribed by computer under my supervision.

Dated this 14th day of November, 2011.



GLYNDE M. JONES, NOTARY PUBLIC

Notary Public Number: 20022120063